# Refugees and AIDS

## UNAIDS technical update

**September 1997**

# At a Glance

HIV can spread fast where there is poverty, powerlessness and social instability – conditions that are often at their most extreme during emergencies. In emergencies of war or civil strife, it is very likely that HIV/AIDS prevention and care services will be severely disrupted or break down altogether. People – no matter how well-informed – will thus be left with little scope to protect themselves, and at a time when they are especially vulnerable.

Factors that encourage the spread of HIV among refugees include:

- the vulnerability of displaced people to sexual abuse and violence
- the possibility that children – who may have little to occupy them and no one to look after them – may become sexually active earlier than they would normally
- the occurrence of prostitution – one of the few survival strategies for people cut off from their normal sources of income
- the displacement of rural populations to heavily-populated areas, where they can suddenly find themselves much more at risk
- the lack of information and clean injecting equipment for injecting drug users among fleeing populations
- the risk that much of the blood used for transfusions may not be screened for HIV.

*Basic responses* in any emergency to prevent HIV transmission include:

- ensuring refugees have access to information and skills training for protection from HIV infection
- ensuring people have the means to protect themselves from HIV, including access to condoms
- providing gloves and other supplies to ensure universal medical precautions and avoid nosocomial transmission of HIV – that is, transmission in health care settings through infected blood
- screening of all donated blood for HIV.

**UNAIDS *Best Practice* materials**

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is preparing materials on subjects of relevance to HIV infection and AIDS, the causes and consequences of the epidemic, and best practices in AIDS prevention, care and support. A *Best Practice* Collection on any one subject typically includes a short publication for journalists and community leaders (Point of View); a technical summary of the issues, challenges and solutions (Technical Update); case studies from around the world (*Best Practice* Case Studies); a set of presentation graphics; and a listing of key materials (reports, articles, books, audiovisuals, etc.) on the subject. These documents are updated as necessary.

Technical Updates and Points of View are being published in English, French, Russian and Spanish. Single copies of Best Practice materials are available free from UNAIDS Information Centres. To find the closest one, visit UNAIDS on the Internet (http://www.unaids.org), contact UNAIDS by email (unaids@unaids.org) or telephone (+41 22 791 4651), or write to the UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

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1. Acquired immunodeficiency syndrome – transmission
2. Acquired immunodeficiency syndrome – prevention and control
3. Refugees
4. Emergencies

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# Background

***In an emergency, the most immediate concern of relief workers is to save people at risk of imminent death from injury, starvation, exposure or disease. In the past, this concern has largely dictated priorities for action. Since the late 1970s and early 1980s, a new threat has arisen – AIDS.***

Until quite recently, preventing the spread of HIV was not seen as a priority in interventions for refugees, especially in the early acute stages, because it is not an immediate threat to life. However, the 1994 Rwanda refugee crisis showed the need to change this view. Never before had there been an emergency of such proportions in a country with such a high prevalence of HIV. It quickly became clear that responding to the epidemic could not be delayed until stability was restored.

For the purposes of planning relief for refugees, emergencies are usually divided into five stages. Not all emergencies follow exactly the same pattern, and sometimes a stage will be missed altogether. It is important to tailor HIV-related action to each stage.

The HIV-related action to be taken will also be determined by the type of emergency. Generally, natural disasters such as earthquakes, droughts and floods do not destroy the national AIDS prevention and care infrastructure, though they may disrupt it locally. In these cases, the focus should be on strengthening the existing capacity to cope. However, in war situations, where there may be little infrastructure left to build on, the immediate task will be one of reconstruction.

### Stage 1: the destabilizing event

This is the event – such as civil war – that "triggers" the emergency, threatening lives and the physical well-being of the population.

### Stage 2: loss of essential services

This is the acute stage. During this period there is a breakdown in the political and social order and in the physical infrastructure. This breakdown, in turn, is likely to cut off access to basic needs such as for food, safe water, shelter, security and health care. Conditions may force people to flee at this stage. On the other hand, escape may not be an option, and people may continue to live amid the chaos. Death and disease rates may be high, and hunger acute. This stage is likely to see the beginning of a national or international relief effort.

### Stage 3: restoration of essential services

This is the stage where national and international responses to the emergency are beginning to have an impact. Essential needs are increasingly being met. While death and disease rates may still be high, the relief agencies are beginning to address a wider range of health problems.

### Stage 4: relative stability

At this stage, services to the affected population – whether in their home country or in refugee settlements outside – are being restored or established. Death rates are considerably lower, and the leading causes of disease have changed. For instance, once safe water supplies are restored, diarrhoeal and acute respiratory infections recede and more people come forward for treatment of chronic conditions such as tuberculosis, malnutrition and sexually transmitted diseases (STDs).

### Stage 5: return to normality

At this point, the original destabilizing event has been resolved, or else is moving towards resolution. A certain degree of political and socio-economic stability has been achieved, and conditions in the displaced population's country or area of origin have improved to the extent that they can consider going home.

# The Challenges

### HIV transmission through blood transfusions

The efficiency of HIV transmission through a transfusion of infected blood is over 90%. In emergency situations, when regular transfusion services may have broken down, it is particularly difficult to ensure the safety of blood transfusions.

### Nosocomial transmission of HIV

Nosocomial transmission means transmission in a health care setting – from a patient to a health care worker (or the reverse), or from patient to patient. The main risks to relief workers are:

- injury with a needle or sharp instrument which has been contaminated with blood
- exposure of their open wounds to infected blood (HIV is not transmitted through unbroken skin)
- splashes of infected blood or body fluids on to mucous membranes or eyes.

Apart from possible infection through a transfusion with infected blood, the main risks of nosocomial transmission to patients are:

- contaminated instruments, such as needles, syringes and scalpels, that are reused without proper disinfection or sterilization
- exposure of open wounds to contaminated blood.

The guiding principle for the control of HIV infection in emergency settings is that all blood should be assumed to be potentially infectious.

### Sexual transmission of HIV and other STDs

Sexual contact involving penetrative sex – whether vaginal or anal – and practised without a condom (unprotected sex) is the most common means of transmitting HIV. This contact may occur in a variety of ways:

- *Sexual coercion, abuse or rape*. Refugees are often physically and socially powerless, with women and children at particular risk. They may often be pressured into having sex, or raped. Sexual violence carries a higher risk of infection because the person violated cannot protect herself or himself from unsafe sex, and because the virus can be transmitted more easily if bodily tissues are torn during violent sex.

- *Prostitution*. The need for money, food and other necessities is one of the major reasons driving women into selling sex and encouraging others to do so. Prostitution very often becomes established in or around refugee camps and usually involves both the refugee and host communities.

- *Vulnerability of children*. Children in refugee camps often have little or no access to HIV information, to schooling or even to recreation. The resulting boredom and ignorance of HIV risks may lead to HIV transmission through experimentation with sex or drug use.

### Lack of health care

Lack of information and STD care leads to a rise in untreated STDs or late treatment. STDs and their complications are a major cause of ill-health (though they may produce no symptoms in women). Moreover, an untreated STD in either partner greatly multiplies the risk of HIV transmission during unprotected sex.

### HIV transmission through drug injecting

If the emergency occurs in an area where drug injecting is common, then injecting may continue in the settlements of the refugees or displaced people. Sharing needles or syringes for injecting, without sterilizing the equipment properly, carries a very high risk of transmitting HIV whenever the virus is present.

**Tibetan refugee camps: the essential minimum package**

The Tibetan refugee health department has designated 1997 as the "Year of AIDS Awareness for Tibetan Refugees". Within the Tibetan refugee camps in southern India, they are launching a community education project on AIDS, and will follow this by setting up a condom distribution system. Their approach is closely modelled on the "essential minimum package" recommended by UNAIDS.

# The Responses

### Stage 1: the destabilizing event

Few HIV/AIDS-related activities can be carried out in this chaotic stage, apart from ensuring an HIV-free blood supply for transfusions. Basic information on the situation regarding HIV and STDs in the emergency-struck area – as well as guidelines – for relief workers and others going into the field, can also be produced or translated into appropriate languages at this point.

### Stage 2: loss of essential services

In this stage, agencies are mainly concerned with saving lives. Only the most basic HIV prevention activities are feasible. The priority here is to provide what is known as the "essential minimum package" for emergency situations, which is made up of the following four responses:

- adherence to universal medical precautions
- measures to ensure safe blood transfusions
- provision of basic HIV/AIDS information
- provision of condoms.

For the last two components of the package, it is important to seek the collaboration of the refugee community itself. It is also extremely important to have good coordination on AIDS-related interventions between all international, governmental and non-governmental agencies.

### Universal medical precautions

Universal precautions are a simple, standard set of procedures to be followed in the care of all patients. They are equally important at *all* stages of an emergency. Their aim is to minimize the risk of transmission of bloodborne infectious agents, including HIV. They consist of the following measures.

1. *Washing hands thoroughly with soap and water.* Handwashing is especially important after contact with wounds or body fluids. If hands are dried with a reusable towel, the latter should be washed regularly.

2. *Gloves.* Protective gloves should be worn for all procedures where there is contact with blood or other potentially infected body fluids. Gloves should be discarded after each patient, or else washed and sterilized before reuse, as appropriate. Heavy-duty gloves should be worn when materials and sharp objects are taken for disposal.

3. *Protective clothing.* Protective clothing – such as waterproof gowns or aprons, masks and eye shields – should be worn when there is likely to be exposure to a large amount of blood.

4. *Safe handling of sharps.* All sharps should be handled extremely carefully, and never passed directly from one person to another. People using them should never try to bend or break needles, nor attempt to recap needles in their sheaths – a common cause of needlestick injuries. Puncture-resistant containers for the disposal of sharps must always be available close by, but well out of the way of children. Sharps should never be thrown into ordinary waste bins or bags.

5. *Safe disposal of waste materials.* People in need of food – and especially small children – may scavenge, so safe disposal of all waste materials is extremely important. Waste material should be burnt, and those materials – such as sharps – which are still a threat should be buried in a deep pit, at least 10 metres away from a water source.

6. *Cleaning and disinfection.* Cleaning of medical instruments between patients is essential. Special attention must be paid to instruments contaminated with body fluids. HIV is inactivated through boiling or the use of chemical disinfectants. Non-reusable equipment – such as disposable needles and syringes – must never be used more than once. Equipment that is reusable should be carefully dismantled and cleaned, and then boiled for at least 20 minutes. Heat-sensitive instruments can be sterilized with various chemical agents, including chlorine-based agents (such as household bleach); 2% glutaraldehyde; or 70% ethanol or 70% isopropanol.

7. *Handling corpses.* HIV can live and reproduce only in a living person. Shortly after an HIV-infected person has died the virus will also die. However, when handling corpses in an emergency situation relief workers should wear protective gloves where possible and cover any wounds on their hands or arms with a plaster or bandage. Relief workers should also wash their hands thoroughly with soap and water afterwards.

### Blood transfusions

All donated blood must be tested. Screening for HIV, and other infectious agents such as hepatitis B virus and syphilis, should be carried out using the most appropriate tests. In acute emergency situations, these tests will be simple or rapid tests. Rhesus testing and simple ABO compatibility testing before transfusions should also be carried out.

Transfusions should be carried out only in life-threatening circumstances and where no other alternative is possible. Blood substitutes – such as crystalloids (saline solutions) and colloids – should be used wherever possible. Blood should be collected from donors who are identified as the least likely to be infected with HIV. Potential donors can be helped to "self-select", by being given clear information about risk behaviour that might have infected them, thus making them unsuitable blood donors. (See Key Materials: UNAIDS, 1996.)

### Information and condoms

Refugees need to be reminded that, in addition to other immediate dangers, HIV transmission remains a threat. They should also be reassured that ordinary everyday contact with HIV-infected people does not constitute a threat. They need appropriate and basic information on how best to protect themselves and others from infection, including how and where to acquire condoms, of which there should be a free supply. And they need to know how to look after themselves if they already are infected with HIV. This means information on where to get medical attention, and information on basic hygiene.

In emergencies, when normal communications are disrupted, people tend to congregate around radio sets for information. The radio is therefore one of the first options to consider for getting out public announcements, and should be used for appropriate messages on AIDS.

**Human rights**

All refugee relief operations must respect and protect human rights. The provision of HIV/AIDS education and services should be seen as part of meeting people's basic rights to life, health, education and information. People have a right, too, to freedom from violence, including sexual violence. Coercion and discrimination (sometimes practised against people living with HIV or AIDS) are never justified. In particular, mandatory testing for HIV has no public health benefit and at the same time violates people's rights, including their rights to privacy and security, and the principles of informed consent and confidentiality.

## Stage 3: restoration of essential services

With a degree of stability now returning, relief agencies can begin to develop more sophisticated and proactive HIV/AIDS interventions. These include:

- assessing the infrastructure of the health system, and deciding what materials and skills are needed for HIV/AIDS activities
- gathering available information on the HIV and STD situations in the affected areas prior to the emergency
- understanding existing risk behaviour and attitudes, and designing interventions to reduce both risk behaviour and discrimination against people with HIV/AIDS (this and the two previous points should be done with the participation of the refugees themselves)
- improving the essential minimum package (described under stage 2), including identifying additional support needed to ensure a continuing and safe supply of blood
- producing information, and undertaking educational and condom promotion activities in the community aimed at encouraging safer sexual behaviour, both among the refugees and the surrounding community. These should include activities which address the special vulnerability of children and adolescents, and which provide constructive ways for young people to participate in the work against HIV/AIDS.
- establishing a programme for the control of STDs, including treatment
- providing clinical care for people with HIV and AIDS.

### Condoms

In the acute phase (stage 2), the most urgent task is to make

good-quality condoms freely available to those who need them. In the post-acute phases, stage 3 onwards, it is important to build on this foundation and to establish "condom programming" – that is, the full range of activities from condom promotion to the planning and management of supplies and distribution.

**STDs**

In most refugee situations there will be minimal or no laboratory facilities for diagnosing STDs. The recommended approach to STD case management – that is, to diagnosing and treating STDs – is the "syndromic" approach, because it is based mainly on a diagnostic physical examination and requires little or no laboratory support. The one exception is to screen for syphilis on-site with simple serological screening tests. Syphilis testing is recommended in pregnant women and for the screening of blood donors.

STD education should be provided, along with information on HIV/AIDS. STD services should be integrated with other health centres or facilities in accessible locations, and should be user-friendly, private and confidential. In most situations, special arrangements will be necessary to make STD care accessible and welcoming to women and young people. (See Key Materials: Inter-Agency Working Group on Reproductive Health in Refugee Situation, 1996; and WHO/FRH, 1996)

**Care**

Comprehensive care for people with HIV-related opportunistic illnesses should be seen as an essential part of basic curative care in any refugee situation. The elements of comprehensive care include:

- clinical management including early diagnosis, "rational treatment" (i.e. coordinated services based on procedural guidelines and prudent use of limited resources) and planning for follow-up care
- nursing care to promote hygiene and nutrition, provide symptom and pain relief (palliative care), and educate individuals and families on AIDS prevention and care
- counselling to help individuals make informed decisions on HIV testing (where this is available) for stress reduction, and to promote safer sex
- social support for people living with HIV or AIDS, including development and training of self-help and other community-based support groups.

The establishment of voluntary testing and counselling programmes for HIV is not a priority during the early stages of an emergency, but it can be considered when relative stability is restored. In the acute stages, it is more important that available resources for HIV testing should be devoted to ensuring a safe blood supply for transfusions.

**Stages 4 and 5: relative stability and normality**

In the return to relative stability and normality, the activities related to HIV/AIDS already described should continue. Mechanisms should now be set up to monitor the key activities and make adjustments to them as necessary.

# Key Materials

*Guidelines for HIV interventions in emergency settings*. Geneva: UNAIDS, 1996 (UNAIDS/96.1) 59-page document developed to enable governments and cooperating agencies, at the earliest opportunity, to adopt measures necessary to prevent the rapid epidemic spread of HIV in emergency situations. (E/F)

*Reproductive health reference materials*. Geneva: Inter-Agency Working Group on Reproductive Health in Refugee Situations, 1996. Reference materials matrix including a section focused on HIV/AIDS/STDs, a one-page list of contact addresses for obtaining references and additional information is provided.

Blood needs in disaster situations: Practical advice for emergencies. *Transfusion International*, 1993, 59:9. Geneva: International Federation of Red Cross and Red Crescent Societies. Tips for organizing blood transfusions in the chaotic conditions prevailing in the aftermath of a catastrophe.

*An inter-agency field manual: Reproductive health in refugee situations*. Geneva: UNFPA/UNHCR, 1995. (UNHCR also has available a video entitled *Reproductive health in refugee situations*, targeted at non-health staff working in refugee situations.) 83-page manual on issues related to reproductive health affecting women, adolescents and men in refugee situations. Intended as a tool to help implement, monitor and evaluate reproductive health-related interventions. (E/F)

*Sexual violence against refugees: Guidelines on prevention and response*. Geneva: UNHCR, 1995. 99-page primer on when and how sexual violence can occur in the refugee context, and on its effects, with basic practical advice in areas of medical treatment, psychological support and legal intervention. (E/F)

*Mental health of refugees*. Geneva: WHO/UNHCR, 1996. 134-page manual focusing on specific learning objectives for relief workers giving practical advice on how to help refugees and displaced people through counselling, self-help groups, modern drugs, and traditional medicine; contains a special section on refugee children. (E)

*Surveillance in emergency situations*. Brussels: Médecins Sans Frontières, 1993. 46-page practical guide on setting up a surveillance system in the early stages of an emergency situation, especially in refugee or displaced camps.

*Reproductive health for refugees. A selected bibliography*. Arlington, VA, USA: John Snow International, 1995. 67-page selected bibliography designed to provide key information to support the rapid development of reproductive health services for refugees and internally displaced persons; HIV/AIDS/STDs is an essential technical area of reproductive health included in the directory.

*Guidelines for the management of reproductive health services during conflict and displacement (draft*). Geneva: WHO/FRH, 1996. 124-page document focusing on health programme managers who have day-to-day responsibility for the management of reproductive health services (including STDs and safe blood transfusion) in situations of conflict or displacement.

*Reproductive health issues in refugee settings (draft).* Atlanta, GA, USA: CARE International, 1996. A 5-day training module for health personnel focusing on skills learning in family planning; HIV/AIDS/STD; sexual and gender violence; maternal care including safe motherhood; and obstetric emergencies. (E)

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