



HIV/AIDS and The Forgotten Majority:

**A Gendered Perspective of States' Fulfilment of the 2001 Declaration of
Commitment on HIV/AIDS amongst Refugee Populations**

By

Sindi-Leigh Tenielle McBride

0606141e

Supervisor: Dr. J. Ala

Masters in International Relations

DECLARATION

I bear witness that this research report is my own unaided work. It is submitted for the Degree of Master of Arts in International Relations at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.

Sindi-Leigh Tenielle McBride

31 August 2011

DEDICATION

There, but by the grace of God, go I. Thank you.

ABSTRACT

Refugees in prolonged states of exile remain neglected and excluded from the international political agenda, in particular refugee women. This research attempts to solve this problem by focusing on HIV/AIDS as a security threat to this group. It recognizes a synergy between protracted displacement, gender and HIV/AIDS and examines the marginalization of refugee women and how this contributes to their vulnerability to infection. This is done by analysing the degree to which host states, Kenya and Tanzania acting as case studies, comply with their international commitments, especially the 2001 UNGASS Declaration of Commitment on HIV/AIDS, in their National Strategic plans for HIV/AIDS and by examining their responses to the socio-economic factors of vulnerability. It also analyses the role played by the international refugee regime, in particular the United Nations High Commissioner for Refugees. It looks at how vulnerability to infection can be mitigated amongst refugee women. Key findings include that refugee women in protracted states of displacement are marginalized by the host state due to their legal status as refugees and are neglected within the host states' National Strategic Plans on HIV/AIDS and that inadequate levels of compliance to the relevant instruments of international law, in particular the Declaration of Commitment on HIV/AIDS, has resulted in host states failing refugee women.

TABLE OF CONTENTS

CHAPTER ONE:	INTRODUCTION	
	1.1. Background	p.7
	1.2. Hypothesis	p.8
	1.3. Case Study Overview	p.10
	1.4. Literature Review	p.11
	1.5. Theoretical Framework	p.13
	1.6. Methodology	p.15
	1.7. Sources	p.17
	1.8 Chapterization	p.17
CHAPTER TWO:	INTERNATIONAL COMMITMENTS	p.19
	2.1. International Law	p.19
	2.2. International Responses	p.23
CHAPTER THREE:	KENYA AND TANZANIA	p.30
	3.1. Background	p.30
	3.2. National Strategic Plans	p.33
	3.2. Commitments	p.38
CHAPTER FOUR:	FACTORS OF VULNERABILITY	p.40
	4.1. Stigma and Discrimination	p.41
	4.2. Breakdown of Social Systems	p.43
	4.3. Sexual and Gender-based Violence	p.45
	4.5. The Armed Forces	p.50
	4.6. Camp Structure	p.53
	4.7. Access to Resources and Opportunities	p.55
CHAPTER FIVE:	CONSTRAINTS TO STATE COMPLIANCE	p.64
	5.1. State-Induced Challenges	p.64
	5.2. Externally-Induced Challenges	p.66
CHAPTER SIX:	RECOMMENDATIONS AND CONCLUSION	p.70
	6.1. Conclusion	p.70
	6.2. Policy Recommendations	p.71
REFERENCE LIST:		p.75

Abbreviations

(AIDS)	Acquired Immune Deficiency Syndrome
(ARVs)	Anti-Retroviral Drugs
(CEDAW)	Convention on the Elimination of all Forms of Discrimination against Women
(FMR)	Forced Migration Review
(GFATM)	Global Health Fund for AIDS, Tuberculosis and Malaria
(GPA)	Global Program on Aids
(HIV)	Human Immunodeficiency Virus
(HSHSP)	Tanzanian Health Sector HIV and AIDS Strategic Plan
(IASC)	Inter-Agency Standing Committee
(IDPs)	Internally Displaced Persons
(KAIS)	Kenya AIDS Indicator Survey
(KNASP)	Kenya National HIV and AIDS Strategic Plan
(MARPs)	Most-at-risk populations
(MDGs)	Millennium Development Goals
(MoT)	Modes of HIV Transmission Study
(NACC)	Kenyan National AIDS Control Council
(NGO)	Non-governmental Organization
(NMSF)	National Multisectoral Strategic Framework
(PEPFAR)	Emergency Plan for AIDS Relief
(RHR)	Reproductive Health for Refugees
(SGBV)	Sexual and Gender-Based Violence
(STDs)	Sexually Transmitted Diseases
(STIs)	Sexually-Transferred Infections
(TACAIDS)	Tanzania AIDS Commission
(TGF)	Ethiopian-backed Transitional Federal Government
(THIS)	Tanzania HIV/AIDS Indicator Survey
(UBU)	Burundi Workers' Party
(UN)	United Nations
(UNAIDS)	United Nations Joint United Nations Programme on HIV/AIDS
(UNESCO)	United Nations Educational, Scientific and Cultural Organization
(UNGASS)	UN General Assembly Special Session
(UNHCR)	United Nations High Commissioner for Refugees
(WHO)	World Health Organization

CHAPTER ONE

1.1. BACKGROUND

The plight of refugees has featured prominently on the international agenda following the establishment of the United Nations High Commissioner for Refugees (UNHCR) in 1950 which was charged with protecting refugees and finding permanent solutions for them¹, as well as the enshrining of refugee rules and procedures in the 1951 Convention Relating to the Status of Refugees and its subsequent 1967 Protocol² which fortified the international refugee regime. This enabled over half a century's humanitarian response and sympathetic attention towards the members of the international community who find themselves in desperate conditions of displacement. And yet, more than 70 percent of the world's refugees are not in emergencies but are caught in protracted refugee situations, where their vulnerability is magnified by precarious living conditions and restrictions on their basic human rights in their country of asylum³. In spite of this, refugees in prolonged states of exile remain neglected and excluded from the international political agenda, with only mass influx situations and high profile refugee emergencies being adequately addressed⁴.

"Among the people hit the hardest by the violence and uncertainty of displacement, are girls, elderly widows, single mothers, - women. As a rule of thumb some 75 percent of these destitute are women and their dependent children."⁵ This popular public relations statement⁶ is widely used and yet the expected concurrent implications for the

¹ Cuellar, M., "Refugee security and the organizational logic of legal mandates", *Georgetown Journal of International Law*, 37 (4), Summer 2006, p.583

² Cross, S., "Refugees and Legal Rules: Can the International Refugee Regime Provide adequate Protection?", http://www.allacademic.com/meta/p_mla_apa_research/citation/1/8/0/7/5/pages180752/p180752-28.php, Accessed 17 May 2010

³ Loescher, G. et al, "Protracted Refugee Situations and Peacebuilding", United Nations University, No.1, 2007, <http://www.un.edu/publications/briefs/policy-briefs/2007/PB01-07.pdf>, Accessed 16 March 2010

⁴ Ibid.

⁵ Turner, S., "Vindicating Masculinity: The Fate of Promoting Gender Equality", p.8, Gender and Displacement, *Forced Migration Review*, Issue 9, December 2000

⁶ Martin, S.F., *Refugee Women*, Women and World Development Series, Zed Books, London, 1991, p.5

protection and development of women within protracted refugee situations have been almost invisible. Add to this the growing threats to human security for most refugees, and the position of refugee women becomes precarious to say the least. Human security encompasses economic, environmental, food, health, personal, community and political security and can be defined as safety for people from both violent and non-violent threats, entailing preventative measures to reduce vulnerability and minimize risk as well as taking remedial action where prevention has failed.⁷ This position is exacerbated by the dual vulnerability of women refugees, who are disadvantaged by their gender as well as by their refugee status as unfortunately for most refugees; threats to their human security are often insufficiently addressed. Far too often they face an untenable position where they are no longer protected by their country of origin and yet do not receive sufficient protection and assistance from their host state. As such, they are the forgotten majority in that the sheer size of their numbers and the lack of regard for their human security have caused to be them a forgotten element of the international community responsible for them.

1.2. HYPOTHESIS

This research plans to divert from the typically refugee-centric approach to forced migration, instead employing a state-centric approach to the realities of refugees' existence by examining the role played by host states in the protection of their security. This will be done by investigating the HIV/AIDS pandemic as a threat to the human security of refugees, from a gendered perspective thus focusing particularly on the security threat to refugee women. This is because it is no longer merely a health issue. Its spread and impact has rendered it one of the greatest, most pervasive and insidious challenges, if not the greatest challenge, facing the international community. In an attempt to address this problem, most United Nations member states signed the *Declaration of Commitment on HIV/AIDS* (henceforth referred to as the Declaration) in June 2001, which recognizes the link between conflict and disaster situations and the spread of HIV. Subsequently, members pledge to incorporate HIV/AIDS into

⁷ Piot, P., "AIDS and Human Security", <http://www.africaaction.org/doc01/piot0110.htm>, Accessed 17 May 2010

programmes that respond to emergencies. The United Nations agencies, regional, international and nongovernmental agencies also agreed to factor HIV/AIDS into their assistance to countries affected by conflict and humanitarian crises.

The extent to which host states have fulfilled the obligations of the Declaration relating to the refugee populations within their borders presents itself as the initial research question but this research recognizes a gap within this issue area; the Declaration pertains only to emergency situations and the incorporation of HIV into programmes related thereto, essentially excluding refugees in protracted situations. Research into the association between HIV transmission and emergency situations has received a fair amount of attention, but the relationship between HIV/AIDS and refugees in the post-emergency phase is often neglected. This is problematic because as refugees spend a longer time in the country of asylum and live in close contact with the local community. Thus, failure to address this threat to their human security not only denies refugees their rights, but also undermines efforts to address the pandemic amongst the host community, as a significant portion of the population is not being attended to. This period provides critical opportunities for refugees to access HIV-related programmes and yet, refugees are often overlooked in the HIV National Strategic Plans in many host countries.

Thus, the research question for this thesis is based on the synergy between HIV/AIDS and human rights, the understanding of which is central to realizing the vulnerability of refugees to infection. Host states have obligations under international refugee law, including the 1951 *Convention Relating to the Status of Refugees* to provide refugees with the same “public relief and assistance” as their nationals, including health care.⁸ In addition, facets of international human rights law also provide the framework for a rights-based approach to responding to HIV/AIDS.⁹ Keeping in mind that this question will be answered from a gendered perspective, focusing specifically on the realities of refugee women, the research question presented is: **“To what extent do African host**

⁸ Goodwin-Gill, G., “Convention Relating to the Status of Refugees and Protocol Relating to the Status of Refugees”, <http://www.untreaty.un.org/cod/avl/ha/prsr/prsrs.html>, Accessed 17 May 2010

⁹ “International Guidelines on HIV and Human Rights, 2006, Consolidated Version, Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS, 2006, www.ohchr.org/english/issues/hiv/guidelines.htm, Accessed 17 May 2010

states implement their obligations under the Declaration of Commitment on HIV/AIDS, and subsequently, protect refugee women against the HIV/AIDS threat to their human security in protracted refugee situations?

This research has a hypothesis that the role of the state in preventing and remedying the pandemic amongst refugee women is significantly superior to that of other relevant actors, such as UNHCR, and that the host state contributes to the vulnerability of this populace, by not complying with international law and norms and by either excluding them from HIV-related programmes or by affecting discriminative policies against them.

1.3. CASE STUDIES: OVERVIEW

Given that Africa is disproportionately affected by both poverty and the HIV/AIDS pandemic, both case studies are provided by African states, namely Kenya and The United Republic of Tanzania. Kenya hosts some 340,000 refugees and is in the midst of a rapidly escalating refugee crisis, with hundreds of new Somali asylum seekers attempting to gain refuge within its borders every day, exacerbating the already chronically overcrowded and underfunded refugee camps, The Dadaab camps have held well over 100,000 refugees since 1992.¹⁰ Tanzania, long one of the world's top refugee-sheltering countries, has been hosting refugees fleeing the convulsions of violent conflict in the Great Lakes region for over the last 50 years and Camp refugee numbers have topped 700,000 as recently as the year 2000, as well as hosting a significant number of refugees who fled from Burundi in 1972 and remain in camps.¹¹ Both cases are characterized by high volumes of refugees, as well as a significant number of refugees caught in protracted states of asylum.

The populations of both host states are characterized by high HIV prevalence levels that interact extensively with the refugee population. They have a notable presence of armed forces interacting with said refugee populations. Both states to date have been shown to enact harsh policies on refugees such as restricting the mobility of refugees, as well as having shown discriminatory tendencies towards refugee women, Kenyan authorities

¹⁰“From Horror to Hopelessness: Kenya’s Forgotten Somali Refugee Crisis”, Human Rights Watch, March 2009, <http://www.hrw.org/en/reports/2009/03/29/horror-hopelessness>, Accessed 17 May 2010

¹¹ “United Republic of Tanzania: Global Needs Assessment”, UNHCR, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e45c736>, Accessed 17 May 2010

having been implicated in sexual violence incidents¹² and Tanzanian authorities offer women very little protection by law against sexual violence, with no law prohibiting discrimination based on sex.¹³

Thus, the case selection was based on the identification of a possible causal mechanism, namely the dominance of the state in influencing the factors that influence the spread of HIV/AIDS amongst the refugee population. In addition, the influence of both local populations regarding existing prevalence and stigma, the dire conditions faced by their refugee populations, women particularly; both reveal the failings of the international refugee regime which has left them vulnerable to discriminative state policies, and subsequently reiterate the supremacy of the state in the protection of this populace against HIV/AIDS as a security threat. The methods of comparison applied are evidently based on similarity, as the parallels between the two case studies are irrefutable.

1.4. LITERATURE REVIEW

Works such as Robert Axelrod's 1984 *The Evolution of Cooperation* and Stephen Krasner's "Structural Causes and Regime Consequences: Regimes as Intervening Variables" in *International Organization* Spring 1982 provide the foundation for understanding Regime Theory whilst the merging of the theory with refugee realities is captured by such articles as Laura Barnett's "Global Governance and the Evolution of the International Refugee Regime" from *International Journal of Refugee Law* 2002 which investigates the shift from the Cold War's influence on the norms and rules of the refugee regime to the need for a form of global governance, with UNHCR having more meaningful influence on the implementation of national law and policy.¹⁴ Julie Mertus' "The State and the Post-Cold War Refugee Regime: New Models, New Questions" in *International Journal of Refugee Law* 1998 continues this thread by identifying challenges to the statist paradigm of this regime in the Post Cold War setting whilst

¹² Callamard, A., "Refugee Women: a gendered and political analysis of the refugee experience" in Ager, A., (ed.): *Refugees*, Pinter, London, 1999, p.205

¹³ "Tanzania", Women Direct, <http://www.womendirectafrica.org/countrydetails.php?countryID=4>, 2008, Accessed 17 May 2010

¹⁴ Barnett, L. "Global Governance and the Evolution of the International Refugee Regime" *International Journal of Refugee Law*, 14 (2 and 3) 2002, p.238

simultaneously exposing the staying power of states as the primary actors within this regime and proposes that trans-sovereign forces are obliged to address the needs of the uprooted when States fail to do so.¹⁵

Unfortunately, the crevice inherent within the Declaration of Commitment on HIV/AIDS, adopted by Member States of the United Nations during the United Nations General Assembly Special Session on HIV/AIDS in June 2001 whereby it only obligates host states to “implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to *emergency* situations”¹⁶ has resulted in a lack of literature pertaining to obligations within protracted refugee situations. Nonetheless, there exists pertinent literature such as the United Nations General Assembly Special Session on HIV/AIDS’ July 2005 policy document “Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators”, which attempts to provide National AIDS Councils (or equivalent) with technical guidance on how to measure the core indicators for the implementation of the Declaration. In addition, the 2006 Report of the UNHCR Secretary-General, “Declaration of Commitment on HIV/AIDS: five years later”, usefully updates on general progress made by member states following their signing of the Declaration as well as identifies challenges and provides recommendations to improve their responses to dealing with the HIV/AIDS pandemic.

Also useful is the Inter-Agency Standing Committee’s (IASC) “Guidelines for HIV/AIDS Interventions in Emergency Settings” which assists in addressing the prevention and treatment of HIV/AIDS within emergency situations but once again, this doesn’t address protracted situations. This dilemma reveals itself again when looking at literature on the role played by UNHCR’s in preventing HIV/AIDS becoming a security threat to refugee women in protracted situations of exile: while there is copious works relating to UNHCR and gender or UNHCR and HIV/AIDS, these pertain only to crisis situations and the combination of these two areas in itself it quite rare.

¹⁵ Mertus, J., “The State and the Post-Cold War Refugee Regime: New Models, New Questions”, *International Journal of Refugee Law*, 10 (3), 1998, p.321

¹⁶ Article 75, Resolution adopted by the General Assembly, 60/262. Political Declaration on HIV/AIDS

Whilst analytical works on the prevalence levels and transmission indicators for the two case studies is rare, statistics are available, both UNHCR and UNAIDS provide reliable yearly updates on the status of UN member states and when used in conjunction with the HIV National Strategic Plans of Kenya and Tanzania, a clear picture may be painted of their HIV/AIDS data and programmes. Whilst narrowly focused literature has been constraining in some areas, fortunately, there is an abundance on the factors that influence the spread of HIV/AIDS amongst refugee women. Broad works include Altman, D., "Understanding HIV/AIDS as a Global Security Issue" in Kelly, L., *Health Impacts of Globalization: Towards Global Governance* and Boelaert, M., "The Relevance of Gendered Approaches to Refugee Health" in Indra, D., *Engendering Forced Migration: Theory and Practice* as well as Forced Migration Review's (FMR) "HIV/AIDS, Forced Migration and Conflict" and "HIV/AIDS/STDs" by the Reproductive Health for Refugees (RHR) Consortium.

Literature pertaining specifically to the various factors includes articles in such publications as FMR's Special Feature on Gender and Displacement, addressing issues such as poor camp structures and The Instituto Promudo's "Promoting More Gender-equitable Norms and Behaviours Among Young Men as an HIV/AIDS Prevention Strategy", which addresses the breakdown of social norms following displacement. UNHCR's 2003 "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response" is one of many but nonetheless critical tool in understanding sexual violence within refugee settings. Works pertaining to the HIV/AIDS amongst refugee women within the chosen case studies, are equally rare by reports by such groups as Human Rights Watch, such as "From Horror to Hopelessness: Kenya's Forgotten Somali Refugee Crisis", as well as Forced Migration Review focus on issues such as Sexual Violence and Conflict with applicable articles such as Kagwanja, P.M., "Ethnicity, gender and violence in Kenya", provide invaluable information. Thus, whilst cumulative, analytical works covering all concerned issue areas are few and far between, it is possible to combine numerous works so as to answer the research question and prove the hypothesis by investigating the various contributing factors and responses by UNHCR and host states by examining their relative policies and responses.

1.5. THEORETICAL FRAMEWORK

When examining the compliance of host states with their international commitments, “no significant distinction exists between international regimes and the rules of purely domestic regimes once the international rules have been domesticated through the passage of implementing legislation”.¹⁷ The onus is on states to domesticate international rules by agreeing to, implementing and making available resources which aid the realisation of international agreements, such as the Declaration. Thus, the theories employed by this research are regime theory and realist theory as the first addresses the significance of regimes as a whole, in this case the HIV/AIDS regime, while the second addresses the role played by states within it.

Regime theory is defined as a set of implicit or explicit principles, norms, rules and decision-making procedures around which actors’ expectations converge in a given area of international relations.¹⁸ It has been applied to security issues, foreign aid and the environment, to name a few issue areas, and is a useful means to analyse how states attempt to solve common problems or achieve common objectives. Regime theorists acknowledge that establishing rules and norms does not guarantee compliance and that sometimes regimes matter and sometimes they do not but nonetheless contribute to state compliance because of the role of norms in the ordering of state cooperation.¹⁹

It is useful to this study because it recognizes the role of state with regard to international relations, viewing it as an integral part of decision-making processes within regimes. With regard to the health regime that has evolved around the HIV/AIDS disease, the transnational nature of the problem means that the rules and behavioural conditions that are implicit within it are often critical. This is because of the potential for providing incentives for rule or norm compliance, and conversely punitive measures for the disregard thereof, such as increased funding by donors or marginalization from

¹⁷ Young, O.R., “Is Enforcement the Achilles’ Heel of International Regimes?”, *Governance in World Affairs*, 1999, p.93

¹⁸ Krasner, D., “Structural Causes and Regime causes: Regimes as Intervening Variables” in Krasner, S. (ed.), *International Regimes*, Cornell University Press, Ithaca, 1983, p.2

¹⁹ Gubin, S.L., “Between Regimes and Realism – Transnational Agenda Setting: Soviet Compliance with CSCE Human Rights Norms”, *Human Rights Quarterly*, Vol.17, No.2, May 1995, p.279

the regime for non-compliant states. Thus, this theory is invaluable in analyzing how the regime contributes to domestic policy because of the latent promise that domestic processes and structures might be positively influenced by the international regime.

Realists view the creation and subsequent significance of international regimes as a result of the power of states to use such institutions to achieve their goals.²⁰ Thus, when addressing compliance within regimes, Realism emphasizes constraints on political power imposed by human nature and the absence of international government, resulting in states acting out of self-interest so as to achieve their own goals. Hence, the core tenets of Realism, such as the centrality of the state within an anarchic international system, explain non-compliance with the principles and rules inherent within regimes, such as the HIV/AIDS health regime. This is best explained by Waltz, who states that “the states interest provides the spring of action.”²¹ It is hypothesized that states play a significant role in the degree to which HIV/AIDS is a security threat to refugee women due to their failure to adhere to their commitments under the Declaration of Commitment on HIV/AIDS, due in part to lack of capacity to respond effectively, but also because it is not always in their interest to do so.

1.6. METHODOLOGY

A case study approach - the detailed examination of an aspect of a historical episode to develop or test historical explanations that may be generalized to other events- has been chosen.²² According to Bennett and George, a case is an instance in a class of events, chosen to study with the aim of developing theory regarding the causes of similarities or differences among instances (cases) of that class of events thus a well-defined aspect of a historical episode.²³ The comparative method is employed whereby a combination of within-case analysis and cross-case comparison is used to draw inferences. This will allow for conceptual validity, where the indicators that best

²⁰ Ibid.

²¹ Waltz, K. in Donnelly, J., *Realism and International Relations*, Cambridge University Press, Cambridge, 2000, p.8

²² Bennett, A. and George, A.L., *Case Studies and Theory Development in the Social Sciences*, The MIT Press, Cambridge, Mass, 2005, p. 5

²³ Ibid, p.18

represent the theoretical concepts of this research will be identified, measured and compared, allowing for contextualized comparison.²⁴

The case selection was based on the identification of a possible causal mechanism, namely the dominance of the state in influencing the factors that influence the spread of HIV/AIDS amongst the refugee population. While the methods of comparison applied are based on similarity, it should be noted there exist substantial variances between the two cases. This thus allows for critical within-case analysis as well as cross-case analysis to elucidate the parallels between the cases.

The approach employed is dependent on the subject material being discussed due to the considerable amount of qualitative data available on the HIV/AIDS pandemic being indispensable but not always sufficient. Qualitative data has been shown to more clearly elucidate points contained within this research, due to the often sensitive and normative nature of the topic.

There are two responses to the HIV/AIDS disease: prevention and treatment and care. The methodology of this study focuses on the first response by examining the epidemiology of the disease as opposed to the biology thereof. The epidemiology of a disease is “the study of the distribution, frequency and determinants of health-related events in human populations.”²⁵ This hypothesis will be proven using refugee women’s risk to infection of HIV as the independent variable and the factors of vulnerability as the dependent variables, using prevalence levels as the core indicator.

The factors of vulnerability to be studied are:

1. The breakdown of social systems leading to risky sexual behaviour
2. Sexual Violence
3. The armed forces as carriers of the virus
4. Inadequate camp structure
5. Insufficient access to resources and opportunities

²⁴ Ibid, p.19

²⁵ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, *FMO Thematic Guide: Forced Migration and Health*, July 2004, <http://www.repository.forcedmigration.org/pdf/?pid=fmo:5147>, Accessed 16 October 2010, p.3

These socio-economic factors of vulnerability have been chosen as dependent variables because they act as the problem areas in which vulnerability to infection can be mitigated by adequate response by the host state. They thus influence the independent variable, refugee women's risk to infection of HIV. The state's compliance with its international commitments within these issue areas will reveal the extent to which the state protects refugee women from HIV/AIDS as a security threat. This research attempts to reveal that despite both countries being characterized by a generalized epidemic, meaning all segments of the population are infected; refugees are marginalized from state initiatives to address the disease. As such there is an opportunity to address areas of concern which could mitigate an increase in prevalence levels, subsequently lessening the threat to refugee women's human security.

Throughout this research, the degree to which host states' comply with their international agreements will be analysed by examining their responses to these factors of vulnerability, in accordance with said international commitments, especially the Declaration. This will reveal the extent to which host states protect refugees against the HIV/AIDS threat to their human security. In Chapter Two, the relevant norms pertaining to state responsibilities to refugee populations, specifically those pertaining to HIV/AIDS, will be discussed and by the end of the chapter, a set of indicators by which compliance can be systematically measured will have been provided which will be continually applied as measurement devices in the case studies.

1.7. SOURCES

Policy documents provide the predominant source of information for this study. These include: *The Declaration of Commitment on HIV/AIDS* produced at the June 2001 UN Special General Assembly, HIV/AIDS policy documents from Kenya and Tanzania, policy documents from UNHCR and agencies of UNAIDS, as well as contributions by NGOs and civil society organisations. In addition, other secondary sources such as books, journal articles and news publications have also been employed, with the internet acting as the medium most employed to access these sources.

1.8. CHAPTERIZATION

Chapter One

The present chapter provides a background to the insecurity which HIV/AIDS poses to refugee women and the responsibility of the host state to fulfil its obligations under the Declaration of Commitment on HIV/AIDS so as to protect them, as well as a general outline of the issues it aims to examine and the literature review, methodology and theoretical framework used to structure the research.

Chapter Two

Chapter two explores the international commitments relating to HIV/AIDS of host states by examining the refugee regime, including refugee law and especially investigating UNHCR. Thereafter the Declaration of Commitment on HIV/AIDS will be examined in detail, as well as other relevant responses or mechanisms created to assist states respond to the pandemic.

Chapter Three

Chapter three explores the HIV/AIDS national strategic plans of the case studies, Kenya and Tanzania so as to allow for later analysis of the independent variables, which are social conditions and state capacity.

Chapter Four

The social conditions which contribute to the spread of HIV/AIDS amongst refugee populations, and particularly those that endanger refugee women will be explored in chapter three. These are: breakdown of social systems, sexual violence, the military, camp structure and access to resources.

Chapter Five

State capacity to fulfil international commitments is discussed in chapter four. These include investigations of infrastructure and resources relevant to HIV/AIDS within refugee communities, as well as constraints to state action such as loan conditionalities.

Chapter Six

The last chapter explores policy recommendations for African states, based on the case studies, so as to improve their fulfilment of their international commitments pertaining particularly to women refugees as well as serves as the conclusion of the thesis, revisiting key issues and restating the answers to the research question posed.

CHAPTER TWO: INTERNATIONAL COMMITMENTS

When the AIDS epidemic was first detected over a quarter of a century ago, few could have imagined the devastating impact it would have on our world.²⁶ It cuts across political, economic and social sectors of the economy. While international commitment to address this has increased considerably, it is inconsistent, particularly with regards to the pandemic in Africa and especially regarding refugees. The first instance of a coordinated response to the pandemic was the Global Program on Aids (GPA), established by the World Health Organization in 1986 but despite a promising start, it was rendered redundant by bureaucratic infighting and the prioritizing of global issues deemed more important such as the fall of communism and environmental protection.²⁷ This sort of shoving under the carpet has consequently characterized international responses to the pandemic over the years, which continues to ebb and flow depending on the agendas of political players such as donor states. This chapter seeks to assess the responses by the international community. However, before this is possible, an understanding of what has informed these responses is necessary. Thus, part one will examine the branches of international law which pertain to HIV/AIDS and refugees and part two will evaluate the success of the efforts and responses by the international community to address the pandemic.

2.1 INTERNATIONAL LAW

International refugee law, international human rights law and humanitarian law complement and reinforce one another relative to HIV/AIDS and refugees. They are each primarily made up of treaties which create binding obligations for the states that ratify them. International refugee law is a set of rules and procedures that aims to protect both people seeking asylum from persecution as well as those recognized as

²⁶ "Declaration of Commitment on HIV/AIDS: five years later", Report of the Secretary-General, *UNGASS Sixtieth Session*, 24 March 2006, p.3

²⁷ Patterson, A., *The Politics of AIDS in Africa*, Lynne Reiner Publisher, Colorado, 2006, p.3

refugees under the relevant instruments.²⁸ It is derived most notably from the 1951 Convention relating to the Status of Refugees and its 1967 Protocol as well as international customary law which is binding on all states and includes such principles as *non-refoulement* which prevents the forcible repatriation of refugees and is considered sacrosanct by most states.²⁹ International humanitarian law - also known as the law of armed conflict or the laws of war - regulates the conduct of warfare based primarily on the four 1949 Geneva Conventions and their two 1977 Additional Protocols.³⁰ Finally, international human rights law is the body of law charged with promoting and protecting human rights in accordance with the 1948 Universal Declaration of Human Rights. The Universal Declaration was adopted after World War II and the bulk of the international legal framework of human rights protection has developed around it with the intention of augmenting it, making the rights contained within it legally binding and subjecting those party to it to monitoring and accountability mechanisms.³¹ The legal protection provided by these bodies often overlap and all are applicable when addressing refugee women affected by the HIV/AIDS pandemic.

The UNHCR 1951 Convention on the Status of Refugees and related Protocol of 1967 address the specific rights of refugees and forms the basis of international refugee law because it requires signatories to treat refugees lawfully staying in their country with the same rights as it affords their own nationals.³² According to Article 23 of the 1951 Convention on the Status of Refugees, "Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and

²⁸ "The Role of Law in Armed Conflicts", <http://www.adh-geneva.ch/RULAC/index.php>, Accessed 8 February 2011

²⁹ Goodwin-Gill, G., "Convention Relating to the Status of Refugees and Protocol Relating to the Status of Refugees", <http://www.untreaty.un.org/cod/avl/ha/prs/prsrs.html>, Accessed 17 March 2010

³⁰ "The Role of Law in Armed Conflicts", Op. Cit.

³¹ Ibid.

³² Roberts, B., "HIV/AIDS, Conflict and Forced Migration", *FMO Thematic Guide: Forced Migration and Health*, July 2004, <http://www.repository.forcedmigration.org/pdf/?pid=fmo:5147>, Accessed 16 October 2010

assistance as is accorded to their nationals”, including medical healthcare.³³ Humanitarian law provides a vital complement to this, as revealed by the 1949 Geneva Conventions and their additional protocols, which apply to non-combatants, such as refugees, which advocate their protection against such atrocities as rape and indecent assault.³⁴ This reveals the obligation to afford refugees the same rights and assistance as is made available to nationals of a host state. Unfortunately, this is seldom the case and worse still, apart from being denied equal access, the basic human rights of refugees are often disregarded by host states. This is problematic because human rights and HIV/AIDS are intrinsically linked. A disregard for basic human rights increases the prevalence and worsens the impact of impact of HIV/AIDS; as such it is a useful framework for understanding and addressing the vulnerabilities of refugees because it helps address societal and contextual factors that determine vulnerability.³⁵ According to the 1948 Universal Declaration of Human Rights:

“Everyone has the right to life, liberty and security of person.” Article 3

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” Article 25(1)

“Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms.” Article 26(2)³⁶

Other key human rights relevant to responding to HIV are: the right to equality and non-discrimination; the right to privacy; the right to information; the right of participation; and the right to work.³⁷ The principle of non-discrimination alluded to is of special importance because both displaced people and those living with HIV/AIDS are

³³ “Convention Relating to the Status of Refugees”, Adopted on 28 July 1951, <http://www2.ohchr.org/english/law/pdf/refugees.pdf>, Accessed 6 October 2010

³⁴ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, p.4

³⁵ Ibid

³⁶ “Universal Declaration of Human Rights”, Adopted on December 10, 1948 <http://www.un.org/en/documents/udhr/index.shtml>, Accessed 17 October 2010

³⁷ Ibid.

frequently subjected to both stigma and discrimination. Article 2 of the Universal Declaration of Human Rights outlines the applicability of rights in spite of “the political, jurisdictional or international status of the country or territory to which a person belongs.”³⁸ Another example of the synergy between HIV/AIDS and human rights is to be found in the right to education and information because those denied this right are left ignorant as to the perils of unsafe sex, increasing their risk of contracting the virus. In addition, the spread of HIV/AIDS also undermines progress in the realisation of human rights, as the pandemic places strain upon the country’s resources, depleting its social capital, by forcing the state to allocate resources to address it, as well as literally, by incapacitating significant numbers of the workforce due to sickness and death thereby undermining attempts to provide a full complement of services as a right to all citizens, including refugees.

The right to health is further entrenched in Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) which states that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for...
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.³⁹

In the refugee context, this reveals an obligation to provide health rights, without mention of citizenship or legal residency⁴⁰, thereby reiterating the importance of no-discrimination. Unfortunately, the collection of international instruments which make up relevant international laws are often insufficient both because they have notoriously weak enforcement mechanisms, and more importantly, because refugees often remain on the periphery of effective protection due to their lack of citizenship, especially when

³⁸ “Universal Declaration of Human Rights”, Op. Cit.

³⁹ “International Covenant on Economic, Social and Cultural Rights”, Adopted on 16 December 1966, <http://www2.ohchr.org/english/law/cescr.htm>, Accessed 13 October 2011

⁴⁰ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, Op. Cit., p.3

hosted by states unwilling or unable to ensure the protection of the rights of their own citizens.⁴¹

2.2 INTERNATIONAL RESPONSES

2.2.1 International Prioritizing of HIV/AIDS

Another indicator of international commitment to the pandemic can be found by examining formal HIV/AIDS policy statements. The 1988 memorandum issued by the Office of the United Nations High Commissioner for Refugees (UNHCR), “Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)” addresses the tenet of international refugee law which advocates that refugees should have non-discriminatory access to care and services in their country of asylum by stating that:

“In every refugee situation in which AIDS or HIV infection is an issue, both human rights and protection principles oblige states and UNHCR to cooperate in the avoidance of individual tragedy. This involves recognition of the fact that exclusion is no solution and that responses must be geared to the dual objectives of combating the disease and protecting the refugee.”⁴²

This was in response to states instituting mandatory HIV screening for international travel and refugee resettlement in the late 1980’s.⁴³ Since then UNHCR has issued other important statements of policy and guidelines regarding refugee protection, such as the 1992 document prohibiting mandatory HIV testing of refugees.⁴⁴ Also important was the updated “Policy and Guidelines regarding Refugees and Acquired Immune

⁴¹ Ibid.

⁴² “Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)”, *HIV InSite Knowledge Base*, November 2011, <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-08>, Accessed 11 October 2011

⁴³ Ibid.

⁴⁴ Ibid.

Deficiency Syndrome (AIDS)” released in 1998, by which time HIV/AIDS had reached pandemic proportions with disastrous results in Africa.⁴⁵ The revised policy states:

“While the **status of being a refugee need not be equated with an increased risk of HIV**, [emphasis in original] it is most important to emphasize that the nature of a refugee environment may increase the vulnerability of the population, especially women, young people and children, to HIV/AIDS. Vulnerability to HIV/AIDS is often created by societal, economic and cultural factors that can affect any given population. HIV spreads fastest in conditions of poverty, powerlessness and social instability – conditions that are often at their most extreme during the refugee cycle.”⁴⁶

This was the first comprehensive practical attempt at articulating UNHCR’s programmatic responsibilities in emergencies, stable settings and resettlement situations and pioneered the implementation of HIV/AIDS policy documents and programs by other humanitarian relief agencies such as the *Interagency Field Manual on Reproductive Health in Refugee Settings*.⁴⁷ It would be prudent to note however that while emphasizing that it is imperative that HIV/AIDS be tackled in cooperation with host states’ national efforts and while promoting action, these responses did not offer specific policy guidance or in any way compel action from states because they do not prescribe action or in any way compel states to take action. While states do need to come up with their own strategies, unique to their epidemic, which cater specifically to their own domestic conditions, the shortcomings of these responses are irrefutable because ultimately, the decision to act upon them was wholly left to the state.

In addition to policy documents, the efforts of the United Nations (UN) to fight HIV/AIDS have also contributed significantly to the prioritising thereof in the international community. During the mid-1990s, the virus was thought of mainly as a health concern to be dealt with by the World Health Organization (WHO), a UN agency. The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 was created to support national governments’ AIDS strategy and coordinate the AIDS activities of UN agencies.⁴⁸ It acts as both a catalyst and coordinator of action, with numerous agencies such as UNESCO and WHO under its umbrella. Also, UNAIDS’

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Ibid.

publications, such as *Guidelines for HIV Interventions in Emergency Settings*, have played a significant role in contributing to HIV/AIDS programmes, including those of UNHCR.

While UNAIDS can be commended for providing a framework for coordinating the UN response, this has unfortunately not been realised within the refugee context, given that HIV/AIDS within protracted refugee situations remains a neglected issue area, a tragedy which is repeated when examining other responses such as the Millennium Development Goals of 2000. These 8 goals range from halving extreme poverty to providing universal primary education to form a blueprint agreed to by the world's countries in an attempt to galvanize efforts to meet the needs of the world's poorest.⁴⁹ In the MDGs, there is, however, no specific reference to the issue of displacement despite the annual report of the Secretary-General on the MDGs making reference to 'protecting the vulnerable'.⁵⁰ Although none of the eight current MDGs deals specifically with refugees, most, if not all, have direct relevance to their plight. Two of the eight goals are of particular importance, namely;

"Millennium Development Goal # 3 - Promote Gender Equality and Empower Women

Target - Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015"

and

"Millennium Development Goal # 6 - Combat HIV/AIDS, Malaria and other Diseases

Target - Halt and begin to reverse the spread of HIV/AIDS."⁵¹

Both of these targets are relevant to women refugees afflicted by the pandemic firstly because the uplifting of women, especially by providing improved education opportunities, would significantly improve their ability to reduce the spread of the

⁴⁹ "UN Millennium Development Goals Background", *United Nations*, <http://www.un.org/millenniumgoals/bkgd.shtml>, Accessed 13 January 2011

⁵⁰ "XVI. Population, Refugees and the Millennium Development Goals: A UNHCR Perspective", *United Nations High Commissioner for Refugees*, http://www.un.org/esa/population/publications/PopAspectsMDG/15_UNHCR.pdf, Accessed 12 January 2011

⁵¹ "HIV/AIDS and Gender: Fact Sheet Overview", *UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS*, http://www.unfpa.org/hiv/docs/factsheet_genderwork.pdf, Accessed 23 October 2010

disease and secondly because the realisation of MDG Goal #6 would significantly decrease the number of refugee women afflicted and affected by the disease. According to the High Commissioner, “Displaced populations should be included in the MDG projects as a way to strengthen protection and durable solutions for them”⁵² but unfortunately, UNHCR’s ability to assess the MDGs is hampered by the fact that refugees are not explicitly addressed within them.⁵³ Another applicable initiative by the international community is to be found in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). Although it was drafted and adopted before the pandemic and does not mention gender equity of HIV/AIDS specifically, it does commit state parties in Article 12 to

“.. take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁵⁴

This has been used by a number of countries to call for improved HIV/AIDS services as well as resulted in the CEDAW Committee releasing its own set of *General Recommendations on HIV/AIDS* (1990)⁵⁵ but once more, these recommendations are based solely on the willingness of the state to act upon them, despite increasing attention within the international community, thus confirming Realist theory’s assertion that regimes are relevant only when states are able to further their own goals within them.

Nevertheless, this combination of policy documents, agency creation and other international responses are developments nonetheless that have assisted in the entrenching of HIV/AIDS on the global agenda and facilitated a flurry of policy documents from UN agencies but more importantly, prompted the release of perhaps the most comprehensive effort to address the pandemic, the Declaration of

⁵² “XVI. Population, Refugees and the Millennium Development Goals: A UNHCR Perspective”, Op. Cit.

⁵³ Ibid.

⁵⁴ “The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)”, Adopted in 1979, <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>, Accessed 12 October 2010

⁵⁵ “HIV/AIDS and Gender: Fact Sheet Overview”, Op. Cit.

Commitment on HIV/AIDS, a final statement of commitment adopted at the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001.⁵⁶ It sets out a number of policy and programmatic resolutions and recommendations. Importantly, it places human rights at the very centre of the international response to the pandemic by basing goals and targets on human rights law, such as stressing the need to eliminate discrimination and empowering women.⁵⁷ It acknowledges the “devastating scale and impact” of the pandemic and concedes that it constitutes “a global emergency” as well as pledges “as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects, as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner.”⁵⁸ While many aspects of the Declaration pertain to both women and vulnerable groups, i.e. refugees, closer inspection of it is necessary to fully grasp the obligations which concern refugee women.

2.2.2 The Declaration of Commitment on HIV/AIDS

Analyzing the extent to which host states implement their obligations under the *Declaration of Commitment on HIV/AIDS*, particularly pertaining to refugee women, requires analysis of some of its key articles, which are listed below, as it is within these particular areas that fulfilment of obligations will be judged.

Declaration of Commitment on HIV/AIDS

HIV/AIDS and human rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women’s full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.

⁵⁶ Ibid.

⁵⁷ “HIV/AIDS and Gender: Fact Sheet Overview”, Op. Cit.

⁵⁸ Articles 1-2, The Declaration of Commitment, Op. Cit.

HIV/AIDS in conflict and disaster-affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities, including participation in emergency humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation for these personnel;

Source: The Declaration of Commitment on HIV/AIDS

A number of observations may be made from the above articles:

1. Firstly, there is an acknowledgment that women are especially affected as well as a commitment to rectify this;
2. Secondly, the relationship between conflict and disasters and the spread of HIV/AIDS;
3. Thirdly, the allocation of responsibility to all those that comprise the international refugee regime. This implies that states are not alone in the fight against HIV/AIDS but the burden of addressing it should be shared with the international refugee regime as well as all actors within the international HIV/AIDS regime, so as to comprehensively involve the international community as a whole;
4. Finally, it is recognized that apart from governments taking the lead in establishing comprehensive national strategies emphasizing gender sensitive HIV/AIDS awareness

and education, national actors such as the armed forces, have a significant role to play because studies have shown that national uniformed services are not only vulnerable to infection but also have the potential to significantly contribute to the addressing of the disease, hence the emphasis on improving HIV/AIDS awareness and training amongst them.

These points inform the analysis of the host states' fulfilment of their obligation but two points need to be stressed before an examination of their national strategic plans is possible. Firstly, these articles have been analyzed because it is possible to discern general threads which will continue throughout this research but other aspects of the Declaration will also be explored e.g. resources and international funding. Secondly, as mentioned earlier, specific policy guidance is lacking and action is not demanded but rather recommended, revealing once more the pre-eminence of the state. Nonetheless, in this chapter the relevant norms pertaining to state responsibilities to refugee populations, specifically those pertaining to HIV/AIDS, were discussed and a set of indicators by which compliance can be systematically measured have been provided. It is at this point possible to proceed to an examination of the national strategic plans of Kenya and Tanzania.

CHAPTER THREE: KENYA AND TANZANIA

Examining the extent to which Africa host states implement their obligations under the United Nations *Declaration of Commitment on HIV/AIDS*, particularly pertaining to refugee women demands close analysis of the two case studies, Kenya and The United Republic of Tanzania. As such, this chapter will first provide a background to each of these, looking in particular at their protracted refugee situations, the extent of the HIV/AIDS pandemic within the country as well as how the two have collided. This will then allow for an examination of their national strategic plans, in order to reveal whether the international commitments which they have committed to are being implemented at a national level.

3.1. BACKGROUND

3.1.1. Kenya

Kenya has been host to over 150,000 Somali refugees over the last fifteen years of Somalia's unrest – a laudable humanitarian gesture recognised all over the world.⁵⁹ Somalia epitomizes for many a situation of constant crisis, a 'black hole' of death and disaster undergoing a process of 'development in reverse'.⁶⁰ The Horn of Africa nation has been subjected to decades of intense inter-clan violence and both severe floods and droughts. In the aftermath of Siad Barre's overthrow after 21 years of rule, the country has been torn apart by competition over scarce resources and criminal activity.⁶¹ Numerous efforts to resolve one of the longest crises of state collapse include countless failed peace conferences as well as military campaigns by neighbouring Ethiopia as well as the United States of America (U.S.)⁶² In spite of this, factional fighting continues between a range of actors, most notably remnants of the Islamic Courts and various

⁵⁹ Ayiera, E., "Bold advocacy finally strengthens refugee protection in Kenya", *Forced Migration Review*, 28, www.fmreview.org/FMRpdfs/FMR28/14.pdf, Accessed 24 November 2010

⁶⁰ Lindley, A., "Crisis and Displacement in Somalia", *Forced Migration Review: Protracted Displacement*, Issue 33, September 2009. p.18

⁶¹ "Routinely Targeted: Attacks on Civilians in Somalia", *Amnesty International*, 6 May 2008, *AI Index: AFR 52/006/2008*

⁶² Ibid.

factions of the Shabab militia, and the establishment of a shaky coalition government has yet to prove itself capable of governing this war torn county.⁶³

Kenya shares a border of well over 600 km with Somalia, and as such, became a natural haven for those fleeing the conflict,⁶⁴ ranging from sporadic influxes to mass movements along the long porous border. The violence following the ousting of the Islamic Courts and the arrival of the (then) Ethiopian-backed Transitional Federal Government (TGF) in 2007 prompted a massive displacement shock, worsening the already serious protracted refugee situation.⁶⁵ This has resulted in the current refugee crisis which escalates daily. “In 2008 alone, almost 60,000 Somali asylum seekers—165 every day—crossed Kenya’s officially closed border with Somalia to escape increasingly violent conflict in Somalia and to seek shelter in three heavily overcrowded and chronically under-funded refugee camps near Dadaab town in Kenya’s arid and poverty-stricken North Eastern Province. The camps now shelter over 260,000 refugees, making them the world’s largest refugee settlement.”⁶⁶ More than two decades after fleeing the brutal conflict in their own country, Somali refugees are faced with an increasingly sour host state, no doubt heavily burdened by this foreign community, but nonetheless hostile to their presence. The authorities continued demonization of this displaced populace as a national security threat has critical implications for the HIV/AIDS pandemic within the community and as such acts as the background to understanding the role played by the state in combating the pandemic amongst refugee women.

3.1.2. Tanzania

The first major wave of mass displacement in Burundi’s recent history followed the 1972 ‘selective genocide’ against the Hutu population, in part inspired by the instability and ethnic persecution that occurred in Burundi when an all Hutu organization known as Burundi Workers’ Party (UBU) began an organized campaign to annihilate all ethnic Tutsi followed by reprisals by the military targeting Hutus.⁶⁷ The number of casualties

⁶³ Ibid.

⁶⁴ “Welcome to Kenya: Police Abuse of Somali Refugees”, *Human Rights Watch*, 17 June 2010, <http://www.hrw.org/en/reports/2010/06/17/welcome-kenya-0>, Accessed 13 September 2010

⁶⁵ Lindley, A., “Crisis and Displacement in Somalia”, *Op. Cit.*, p. 19

⁶⁶ “From Horror to Hopelessness: Kenya’s Forgotten Somali Refugee Crisis”, *Op. Cit.*, p.32

⁶⁷ Ibid.

has never been established but it is undeniable that the conflict produced one of Africa's most prolonged refugee situations, with over 200,000 Burundian refugees having lived in designated settlements in western Tanzania, known as the Old Settlements, for over 35 years.⁶⁸ Historically, Tanzania has been a haven for refugees, providing safety and refuge to thousands fleeing intractable conflicts from not just Burundi but Rwanda and the Democratic Republic of Congo too, going as far as to offer settlement, reintegration and even citizenship at times.⁶⁹ Interestingly, Tanzania is similar to Kenya in that its generosity began to dry up following an increasing influx of refugees in the 1990s, prompted by increased conflict in the Great Lakes region, subsequently resulting in growing hostility towards refugees as well as a hardening of refugee policies.⁷⁰ In both cases, this reflects a trend of host states undermining refugee protection when faced with a refugee situation perceived as untenable.

According to UNHCR, a protracted refugee situation is "one in which refugees find themselves in a long-standing and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years of exile."⁷¹ This results in restrictions on their rights and eventually gives rise to problems of national security as the host state feels overwhelmed by escalating refugee problems which are either merely perceived to be of national concern or in fact are translated into problems for the host state. It is in this context that we examine the problem of HIV/AIDS with regards to the refugees, and more specifically, how these host states have responded to the pandemic amongst their own populations as well as with regard to their refugee communities. The next section will provide a profile of the epidemic in Kenya and Tanzania, so as to later progress to an evaluation of the host state's response to the factors which increase vulnerability.

⁶⁸ Thomson, J., "Durable solutions for Burundian refugees in Tanzania", *Forced Migration Review: Protracted Displacement*, Issue 33, September 2009. p.35

⁶⁹ "Tanzania: In the Name of Security", *Human Rights Watch*, July 1999, Vol.11, No.4, <http://www.hrw.org/legacy/reports/1999/tanzania/>, Accessed 18 November 2010

⁷⁰ Ibid.

⁷¹ Loescher, G. and Milner, J., "Responding to Forced Migration in a 'Reforming' UN System: The case of Burundian refugees in Tanzania", *Forced Migration Policy Briefing 6*, Refugees Studies Centre, January 2011, <http://repository.forcedmigration.org/pdf/?pid=fmo:5937>, Accessed 19 January 2011

3.2. NATIONAL STRATEGIC PLANS

3.2.1. Kenya

Kenya has one of the world's harshest HIV/AIDS epidemics, with an estimated 1.5 million people living with HIV, and millions more affected by the disease.⁷² The Kenyan government was criticised for its belated response to the disease, which emerged in earnest in the late 1980s and spread rapidly until it peaked in 2000.⁷³ The government declared HIV as a national disaster in 1991 and established the National AIDS Control Council (NACC) to coordinate a multi-sectoral national response.⁷⁴ To date, it has led the national response to the pandemic by coordinating two five-year strategic plans, Kenya National HIV and AIDS Strategic Plan (KNASP), with most response covering the periods 2000 to 2005 and 2005/06 to 2009/10, and is currently embarking on its third plan, for the period 2009/10 to 2012/13, KNASP III.⁷⁵ The previous plan, KNASP II, focused on three priority areas: (1) Preventing new infections; (2) Improving the quality of life of people infected or affected by HIV; and (3) Mitigating the socioeconomic impact of HIV⁷⁶. According to the Modes of HIV Transmission Study (MoT) in 2008, and Kenya AIDS Indicator Survey (KAIS) in 2007, significant progress has been made in the fight against HIV, with prevalence levels having decreased from 13.4% in 2000 to 6.9% in 2006, primarily due to preventative interventions as well as a large number of people having died from the disease, which totally 150 000 in 2003 alone.⁷⁷ And yet, new infections are estimated at 166,000 annually.⁷⁸

As such, the Minister of State for Special Programmes, Hon. Dr. Naomi Shaban, has called for a doubling of efforts to turn off the tap of new infections while simultaneously providing care and support for those already living with HIV, with the clarion call for

⁷²"HIV/AIDS in Kenya", AVERT, <http://avert.org/hiv-aids-kenya.hym>, Accessed 8 February 2011

⁷³ Ibid.

⁷⁴ "Kenya National AIDS Strategic Plan 2009/10 – 2012/13", National AIDS Control Council, November 2009, http://www.ilo.int/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127531.pdf, Accessed 21 January 2011, p. 1

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ HIV/AIDS in Kenya", *Op. Cit.*

⁷⁸ Ibid, p. viii

this strategic plan being “Delivering on Universal Access to Services”.⁷⁹ This begs for closer analysis so as to ascertain if this is a realistic expectation or not.

Kenya’s epidemic has been categorised as generalized meaning it affects all sectors of the population and HIV prevalence in the general population exceeds 1%.⁸⁰KNASP III attributes new adult infections to both heterosexual sex within a union and casually, homosexual sex, sex work as well as due to injected drug use.⁸¹ In addition, it catalogues growing trends within the pandemic which include high levels of HIV within marriage/regular partnerships, low levels of knowledge about HIV status and a growing mismatch between service provision and geographical prevalence.⁸² It scores points for outlining the growing gender dimensions of the epidemic, revealed by the increased ‘feminisation’ of the epidemic, with prevalence levels amongst women significantly higher than among men.⁸³ It also pays special attention to most-at-risk populations (MARPs), primarily thought to be sex workers, listing the challenges faced when attempting to address their needs such as overall lack of data about their numbers, their marginalisation from formal health services as well as denial and social intolerance within their communities.⁸⁴

It would appear that this National Strategic Plan is comprehensive in its efforts to address the sources of infections and the challenges faced in addressing them but when it is taken into consideration that this plan makes no mention of refugees whatsoever, gaping holes appear. Kenya has a variety of localised HIV epidemics across the country, with diverse causes and outcomes and the epidemiological dynamics are complex because of differing modes of transmission.⁸⁵ The characteristics of the epidemic are those of both a generalised epidemic among the mainstream population, and a ‘concentrated’ (affecting less than 1% of the general population but with high prevalence levels within a certain group) epidemic among specific most-at-risk

⁷⁹ Ibid.

⁸⁰ Wilson, D., “HIV Epidemiology: A Review of Recent Trends and Lessons”, *Global HIV/AIDS Program*, The World bank, 13 September 2006

⁸¹“Kenya National AIDS Strategic Plan 2009/10 – 2012/13”, *Op.Cit.*, p.7

⁸² Ibid, p.5-6

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Ibid.

populations⁸⁶ so to completely neglect a significant portion of the population seems absurd to say the least, especially when taking into consideration that the refugee populace is comprised of both of these groups. This begs the question, should refugees be specifically mentioned? This research asserts that given that they are not classified as members of society and yet constitute a considerable part of the population, specific mention is mandatory.

In addition, the challenges faced when addressing the needs of MARPs are ironically very similar to those faced by refugees i.e. insufficient data, marginalisation and exclusion from formal health services and social intolerance and stigmatization within their communities. Refugees are mentioned once in the entire plan, in an expected output targets plan, focusing on prevention targets, with figures to be attained by the end of KNASP III but no programmatic targets, strategies or service plans are mentioned to make this a reality.⁸⁷ The outcomes of KNASP III are similar to those of its predecessor in that it focuses firstly on preventing new infections, specifically stating that its first intended outcome is to achieve “reduced risky behaviour among the general, infected, most-at-risk and vulnerable populations”⁸⁸but this seems highly unlikely with a significant portion of it being excluded. Delivering on Universal Access to Services?

3.2.2 Tanzania

Similarly, Tanzania’s epidemic is also characterized as generalized. About 1.2 million people in Tanzania are living with HIV and while the number has fallen slightly, the epidemic’s severity varies from region to region, with some regions reporting a prevalence of less than 2% and others as high as 16%.⁸⁹Interestingly, the theme of the Tanzanian Health Sector HIV and AIDS Strategic Plan (HSHSP), the contribution of the health sector to the overall National Multisectoral Strategic Framework (NMSF), for the period 2008-2012 is “Universal Access to Preventative, Care, Treatment and Support

⁸⁶ Ibid, xiii

⁸⁷ Ibid, p.54

⁸⁸ Ibid, p.13

⁸⁹ ⁸⁹“HIV/AIDS in Tanzania”, AVERT, <http://avert.org/hiv-aids-kenya.hym>, Accessed 8 February 2011

Services”, very similar to that of Kenya’s national strategic plan. The body responsible for ensuring this is the Tanzania AIDS Commission (TACAIDS), responsible for developing and adjusting a multi sector National HIV and AIDS Strategic Framework with the intention of addressing HIV/AIDS in a comprehensive and multi sectoral manner so that NMSF contributes to Millennium Development Goals, universal access to HIV services, overall national development, poverty reduction and in doing so, attains the aspirations laid out in Vision 25.⁹⁰

This vision is essentially “To reduce the incidence of absolute poverty to 10% and relative poverty to 30% of the total population by the year 2017”, with the Health Sector contributing to this national effort by “Working in partnership with other public sectors, private sector, civil society and communities to play a leading role in the prevention of further spread of HIV/AIDS and mitigate its impacts by providing essential interventions and quality care.”⁹¹ It intends to achieve this by proposing three goals: (1) to scale up the health sector response to HIV and AIDS and strengthen the health system capacity, (2) to support HIV and AIDS interventions and to promote access and utilization of affordable and essential interventions and commodities for HIV and AIDS, and (3) to improve the quality of HIV and AIDS interventions to the general public, health care providers and other vulnerable populations.⁹² In addition, it proposes that certain principles guide the realisation of these goals, these include: equity of access, ethical conduct and human rights, accountability and rectifying gender imbalances.⁹³

Tanzania’s plan scores points for including detailed sections on the burden of the disease as well as its epidemiological character, stating that according to the Tanzania HIV/AIDS Indicator Survey (THIS) of 2003/4, the predominant mode of transmission has remained heterosexual contact, constituting about 80% of all new infections and that Tanzania is facing a ‘generalized’ epidemic of HIV.⁹⁴ It addition, it includes a comprehensive analysis of gender and HIV/AIDS, not only acknowledging that women

⁹⁰ “Health Sector HIV and AIDS National Strategic Plan (HSHSP) 008-2012”, The United Republic of Tanzania Ministry of Health and Social Welfare, http://hdptz.esealttd.com/fileadmin/documents/Key_Sector_Documents/HIVAIDS_Documents/HIV_AIDS_Sector_Strategic_Plan_June_07.pdf. Accessed 21 January 2011, p.12

⁹¹ Ibid, p.20

⁹² Ibid.

⁹³ Ibid, p.21

⁹⁴ Ibid, p.13

bear a greater burden than men but attributing it to unsafe sexual behaviour by males, female subordination and a lack of female economic independence, stating that “more than 70% of sexually active out-of-school girls reported granting sexual favours for basic daily needs, having relationships with older men.”⁹⁵ Unfortunately, instead of pledging increased protection for women, it merely states that “since men assume more assertive and directive roles in sexual decision-making, they need to be addressed not only as beneficiaries but also as central in the fight against HIV and AIDS.”⁹⁶

It prioritizes four themes, focusing on specific strategic objective targets within the areas of prevention; treatment, care and support; cross-cutting issues such as laboratory services and national health system strengthening.⁹⁷ Within the intervention area of preventing further infections, special attention is paid to preventing and managing the transmission of sexually-transmitted infections as a way of preventing the worsening thereof, and two vulnerable groups are targeted: youths and broader group including commercial sex workers, prisoners and homosexuals.⁹⁸ The only mention of refugees within this seemingly comprehensive plan is to be found here. In defining vulnerable groups, it states that

“Vulnerability to HIV infection is substantially higher in specific population groups than in the general sexually active population. This is either related directly to their professional activities (commercial sex workers), to their social and cultural marginalization (Men who have sex with men), or associated to their professions bringing them either in frequent contact with places of sexual mixing (bar maids), necessitating longer periods of separation from families or stable relationships (prisoners, migrant workers including miners, military) or the complete breakdown of stable social environment (refugees, intravenous drug users). There are other vulnerable groups like those who are either mentally or physically challenged and orphans. These groups need special attention because of their importance in the dynamics of the epidemic when they act as a bridge for transmission from their sub group to the general population.”⁹⁹

While this is an improvement on Kenya almost complete lack of mention of refugees, apart from acknowledging that the poor social conditions of refugees demand special attention, no other mention is made as to what this attention should include or any

⁹⁵ Ibid., p.15

⁹⁶ Ibid.

⁹⁷ Ibid, p. 7-10

⁹⁸ Ibid, p.31

⁹⁹ Ibid.

other strategy as to how best to deal with this sub group. In addition, this special mention has negative connotations in that it can very easily be misconstrued by the local population to mean that these vulnerable persons, refugees included, are responsible for the transmission of the disease to the general population. This reveals that by excluding refugees from action plans as well as opening up the possibility of discrimination against them, Tanzania's Health Sector HIV and AIDS Strategic Plan disregards its own principles of equity of access and ethical conduct and human rights. In much the same way as Kenya does, it falls short of protecting refugees, and by extension refugee women. It is at this point possible to proceed to an evaluation of its international commitments so as to assess the extent to which their obligations are being fulfilled, and if not, determine the obstacles preventing this.

3.3. COMMITMENTS

The Commitments examined in earlier chapters, have all been adopted by both Kenya and Tanzania, for example, the UN International Covenant on Economic, Social and Cultural Rights (1966), has been ratified by both¹⁰⁰ as well as the UNHCR Convention on the Status of Refugees (1951) and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW),¹⁰¹ in addition to the Universal Declaration of Human Rights (1948). Also, both are parties to regional instruments which entrench the commitments and principles enshrined in the previous instruments. An example of this is the African Union Charter on Human and Peoples Rights which states that "Every individual shall have the right to enjoy the best attainable state of physical and mental health"¹⁰², and has been signed and ratified by both.¹⁰³ The exclusion of refugees from

¹⁰⁰ "Database and Legislation", <http://www.unesco.org/shs/ethics/geo/user/?action=Geo4View&db=GEO4&id=1&type=TREATY&lng=en&criteria=Tjs%3D>, Accessed 12 January 2011

¹⁰¹ "Status of Treaties", Chapter IV: Human Rights, *United Nations Treaty Collection*, 7 January 2011, <http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>, Accessed 13 September 2011

¹⁰² Article 12, "African Charter on Human and People's Rights", adopted June 27, 1981, <http://www.umn.edu/humanrts/instree/z1afchar.htm>, Accessed 13 November 2010

¹⁰³ "List of Countries which have signed, ratified/acceded to the African Charter on Human and People's Rights", <http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf>, Accessed 12 January 2010

their national strategic plans disregards these obligations and in this way, does not afford them the protection that the host state is responsible for.

Having provided a succinct examination of the profile of the epidemics in Kenya and Tanzania, a deeper analysis of what these countries are doing to address the spread of the disease amongst refugee populations is needed. To do this, evidence is needed which will assist with the answering of this research's questions. This is provided by the dynamics that make HIV/AIDS a threat to refugee women, who are statistically more vulnerable than men and more adversely affected by the epidemic. The factors that contribute to their insecurity to be examined are the breakdown of social systems due to displacement, sexual violence, the military, camp structure and finally, access to resources. In this way, the extent of the vulnerability will be examined, the response of the host state to these factors in relation to their obligations as well as the role played by the rest of the refugee regime e.g. UNHCR. In this way, the shortcomings of the host state will be revealed, which will allow for later analysis of its capacity to deal with the issues engendered by the intersection of asylum provision and the HIV/AIDS pandemic.

CHAPTER FOUR: FACTORS OF VULNERABILITY

In this chapter, the factors that contribute to the vulnerability of refugee women to HIV/AIDS will be examined, in particular the host states' role therein. There are two responses to the disease; prevention and treatment and care. Prevention includes the provision of male and female condoms, preventing mother-to-child transmission as well as the treatment of sexually transmitted diseases (STDs), in addition to interventions to alter risky sexual behaviour.¹⁰⁴ Treatment and care includes the use of antiretroviral drugs which delay the onset of full-blown AIDS, as well as the treatment of opportunistic infections such as pneumonia or tuberculosis, which arise from HIV/AIDS.¹⁰⁵ This study focuses on the first response but recognizes that those susceptible to infection do not always have the incentive or power to change their vulnerability, and as such, the structural socio-economic factors that increase said vulnerability need examination. For this reason, the biology of the disease is not focused upon, but rather, the epidemiology of HIV/AIDS, which is "the study of the distribution, frequency and determinants of health-related events in human populations."¹⁰⁶ According to Barnett and Whiteside, "pathways of infection are mapped onto social, cultural and economic relations between groups of human beings... We all share the same world, but unequally, so are differentially exposed to disease organisms."¹⁰⁷

The most common epidemiological measurement of HIV/AIDS is prevalence levels, however there are numerous challenges associated with using this within the context of forced migration. The most fundamental challenge is to be found in the fact that in both case studies, there is a generalized epidemic, meaning it affects all segments of the population. However, this research has attempted to reveal the marginalization of refugees from the general population and this chapter seeks to display the vulnerability of refugees to infection. Statistical data about the prevalence levels amongst refugees is almost non-existent, naturally as a result of this marginalization, and as such, in revealing the factors of vulnerability, this research seeks to point out the socio-

¹⁰⁴ Roberts, B., "HIV/AIDS, Conflict and Forced Migration", *Op. Cit.*, p.3

¹⁰⁵ Ibid, p.4

¹⁰⁶ Ibid

¹⁰⁷ Barnett, T. and Whiteside, A., *AIDS in the Twenty- First Century*, Palgrave MacMillan, New York, 2002, p.65

economic areas where preventative measures could be taken to lessen vulnerability to infection. It is within these areas that state compliance with their international commitments affects the degree to which HIV/AIDS is a threat to refugee women because of the seldom acted upon possibility of mitigating these factors of vulnerability.

Other challenges presented by prevalence levels as a measurement of analysis include whether the prevalence levels have increased due to new risk factors or simply changing numbers in the population, problems with unreliable statistics, fears of persecution or involuntary repatriation leading refugees to shy away from authorities as well as, as has been mentioned in the previous chapters, displaced populations simply being left of the host state' agenda.¹⁰⁸ The challenge of increased prevalence levels possibly being a result of more changing population numbers is somewhat mitigated by the case studies being of protracted refugee situations , but the constant flow of new refugees into both Tanzania and Kenya does present a problem. Nonetheless, the factors that increase vulnerability to becoming infected with the virus, as well as the treatment of those already infected so as to prevent further infections demands critical inspection. These are; the breakdown of social systems due to displacement, sexual violence, the military, camp structure and finally, access to resources which might contribute to preventing the spread of the disease. An overview on each of these problem areas will be provided, followed by the respective host states' response as well as an evaluation of whether this is in keeping with its obligations under international law, the Declaration in particular. It should be noted however, that the gravity of these factors varies between the two case studies, with some presenting a more serious problem than others. In addition, responses by other actors, such as UNHCR will be provided so as to judge that of the host state. Before this is possible however, a brief overview of the cloud that hangs over the disease, stigma and discrimination, needs exploration as this has the potential to, and at times does in fact, add force to the other factors.

4.1. STIGMA AND DISCRIMINATION

"From the beginning, the HIV/AIDS epidemic has been accompanied by an epidemic of fear, ignorance, and denial, leading to stigmatization of and discrimination against

¹⁰⁸ Roberts, B., "HIV/AIDS, Conflict and Forced Migration", *Op. Cit.*, p.5

people with HIV/AIDS and their family members.”¹⁰⁹ According to UNAIDS, HIV/AIDS-related stigma is defined as a “process of devaluation” of people either living with or associated with HIV/AIDS, most often stemming from underlying stigmatization of sex and drug-use, both primary causes of the transmission of the disease.¹¹⁰ This builds upon existing prejudices by playing into and strengthening existing social inequalities, especially gender, sexuality, race, and in the case of refugees, nationality or refugee status. This is detrimental because it deters people from learning their HIV status for fear of being ostracized by their communities, a fear often compounded by insecurity of their legality, making refugee communities especially vulnerable to high transmission rates due to those infected ignoring their status. Consequently, HIV-related stigma is increasingly recognized as the single greatest challenge to slowing the spread of the disease.¹¹¹

Discrimination is the unjust treatment of people based on their status, or perceived status, usually following stigmatizing. This is usually based on ignorance or an inadequate understanding of the modes of HIV transmission. When combined with a better understanding of the deadliness of the disease, this exacerbates the ostracizing of those affected by the disease. In the refugee context, this is especially manifested on the political level, when refugees are faced with harsher treatment by authorities i.e. the threatening of compulsory HIV/AIDS testing or on the socio-economic level¹¹² when refugees are doubly disadvantaged by reduced education or employment opportunities based on their HIV status as well as their refugee status. The combination of these two challenges is worrying because it causes refugees to shy away from authorities, including health services, for fear of persecution in the form of repatriation or harsh treatment, a reaction that merely compounds the spread of the disease.

¹⁰⁹ “Addressing HIV-Related Stigma and Resulting Discrimination in Africa: A Three-Country Study in Ethiopia, Tanzania, and Zambia”, Information Bulletin, ICRW March 2002, p.1

¹¹⁰ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, Op. Cit., p.25

¹¹¹ “Addressing HIV-Related Stigma and Resulting Discrimination in Africa: A Three-Country Study in Ethiopia, Tanzania, and Zambia”, Op. Cit.

¹¹² Ibid.

4.2. BREAKDOWN OF SOCIAL SYSTEMS

Norms in this context may be defined as regulative norms, which order and constrain behaviour, constitutive norms, which create categories of action, or prescriptive norms whose quality of “oughtness” sets norms aside from other kinds of rules.¹¹³ Social norms play a significant role in the epidemiology of HIV/AIDS because they shape perceptions of sex by dictating what behaviour is acceptable or unacceptable. Unfortunately, displacement causes social upheaval. This means that the consequences of exile seriously affect the structure of families and societies. The implications of this for the transmission of HIV/AIDS is multitudinous because the norms that regulate sexual behaviour are often lost away from the comforts of traditional society, often resulting in riskier sexual behaviour. This increases vulnerability to the disease an example being the need to replace lost loved ones with new partners.¹¹⁴ Thus, the breakup of stable relationships and the loss of mutual support and the loosening of controls on social behaviour render refugees vulnerable to infection.¹¹⁵

Also, in the absence of formative social structures, adolescents, young men in particular, are more likely to engage in risky behaviour such as drug or alcohol abuse, consequently increasing risky sexual behaviour. An analysis of young Burundian men in Tanzanian refugee camps revealed that feelings of general social decay and emasculation abound as old values and norms about essential issues such as relationships between husbands and wives, as well as dating practices, are challenged by the refugee camp regime.¹¹⁶ This also hints at the changes in gender relations within the camp setting which no doubt has consequences for the spread of the disease. According to the aforementioned study, young men in camps are often found at a junction in their life where they are supposed to be creating families for which to provide

¹¹³ Finnemore, M., and Sikkink, K., “International Norm Dynamics and Political Change”, *International Organization*, 52, 4, Autumn, 1998, p.891

¹¹⁴ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, *Op. Cit.*, p.7

¹¹⁵ *Mobile Populations and HIV/AIDS in the Southern African Region*, IOM-UNAIDS Reports on Mobile Populations and HIV/AIDS, *International Organization for Migration*, Geneva, 2003, p.73

¹¹⁶ Turner, S., “Angry Young Men in Camps: Gender, Age and Class Relations among Burundian Refugees in Tanzania”, http://www.genderandpeacekeeping.com/resources/6_Angry_Young_Men.pdf, Accessed 13 October 2010, p.5

and protect but instead their process of identity creation is disrupted by life in a refugee camp, often forcing them to act aggressively in an attempt at self-assertion.¹¹⁷

Evidently, this begs an analysis of the relationship between gender norms and HIV/AIDS because they interact on multiple levels and in many different ways, especially because

“personal risk of contracting HIV is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviours. Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society’s institutions and practices. Socio-cultural norms build notions of masculinity and femininity which in turn create unequal power relations between men and women.”¹¹⁸

Firstly, there exists a culture of silence around sex that dictates that “good” women are expected to be ignorant and passive in sexual interactions, making it difficult for them to request information about the disease. Norms relating to masculinity can however be just as negative. Men are disadvantaged by prevailing norms which dictate that they are knowledgeable about sex, thereby also preventing them from acquiring information for fear of being regarded as incompetent. Also detrimental are norms positing multiple sexual partners as essential to male nature, based on “a hydraulic model of male sexuality which seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or the reduction of number of partners.”¹¹⁹ Other practices which reinforce the correlation between gender norms and vulnerability to HIV/AIDS include female genital mutilation, child marriages and norms surrounding the sexual practices of virgins however within the refugee context, the most influential are to be found in those relating to notions of masculinity which emphasize sexual domination over women as a defining characteristic of malehood.¹²⁰ Empirical evidence in African states has demonstrated that the high male control in intimate relations is generally

¹¹⁷ Ibid, p.6

¹¹⁸ Banerjee, S. And Sharma, U., “Gender, Sexuality, Rights and HIV: An Overview for Community Sector Organizations”, International Council of AIDS Service Organizations, 2007, <http://www.icaso.org/publications/genderEN1.pdf>, Accessed 21 October 2010

¹¹⁹ Gupta, G.R., “Gender, Sexuality and HIV/AIDS: The What, the Why and the How”, Plenary Address XIIIth AIDS Conference Durban, South Africa, 12 July 2000, <http://www.genderandaids.org/modules.php?name=News&file=articles&sid=36>, Accessed 24 October 2010

¹²⁰ Ibid.

associated with increased HIV high risk behaviours and infection such as low condom use, maintaining multiple sexual partners, early sexual initiation, substance abuse, violence and delinquency.¹²¹ In the refugee context, this is exacerbated by boredom and substance abuse due to insufficient opportunities for either education or employment, and when coupled with the frustration of emasculation felt by young men in camps, creates a hazardous situation for refugee women, because this often translates into sexual violence.

According to Heather McLean's investigation and analysis of gender and power structures in refugee camps however, "displacement definitely creates a space for fundamental changes in these existing power structures", arguing that displacement removes the permanence of social relations, thereby creating the possibility of a shift in power differentials.¹²² Unfortunately, the absence of the host state in the refugee camps, especially with regard to social dynamics, means that this opportunity for change is not grasped. Instead, the policies of agencies such as UNHCR take precedence in shaping gender roles within the refugee camp, not always with positive results. The enforced equality within refugee camps, where women, children and men receive equal amounts of assistance from the relief agency is positive on paper but has resulted in lamentations that 'The UNHCR is a better husband'¹²³, as men feel more emasculated. Given that the host state does not afford refugee women with increased protection to accompany this equality, it is in fact an empty victory, further contributing to their vulnerability as the tedium of camp life is felt by men and they are forced to bear the brunt of it.

4.3. SEXUAL AND GENDER-BASED VIOLENCE

Continuing the analysis of social norms, perhaps most worrying about the dynamics of gender norms within the refugee context is the increase in sexual and gender-based

¹²¹ Chege, A., "Interventions linking gender relations and violence with reproductive health and HIV: rationale, effectiveness and gaps", Population Council's FRONTIERS Agenda Special Focus, 2005, http://www.popcouncil.org/pdfs/frontiers/journals/Agenda_Chege05.pdf, Accessed 24 October 2010

¹²² Brown, G. K., "Gender Roles in Refugee Camps: The Lasting Impact of Refugee Interventions in Tanzania", May 2006, <http://fletcher.tufts.edu/research/2006/Brown.pdf>, Accessed 22 November 2010, p.10

¹²³ Turner, S., "Angry Young Men in Camps: Gender, Age and Class Relations among Burundian Refugees in Tanzania", *Op. Cit.* p.2

violence (SGBV). It is well documented that this constitutes a widespread international public health and human rights issue, and that adequate, appropriate, and comprehensive prevention and response are inadequate in most countries worldwide¹²⁴ but this is complicated further in the refugee context. SGBV is most prevalent when there is a general lack of respect for human rights but it is also in itself a grave human rights violation¹²⁵ because it infringes upon numerous universal human rights, including the right to security of person, the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment; and the right to life.¹²⁶

In the context of displacement, women and children are targeted because they are most vulnerable simply because of their gender, age and status in society. According to UNHCR's *Guidelines for Prevention and Response*, the types of SGBV experienced by refugees in the country of asylum include "sexual attack, coercion, extortion by persons in authority; sexual abuse of separated children in foster care; domestic violence; sexual assault when in transit facilities; sex for survival/forced prostitution; sexual exploitation of persons seeking legal status in asylum country or access to assistance and resources, resumption of harmful traditional practices."¹²⁷ The irony and sadness of the situation is that most of these women are forced to endure sexual violence during both conflict and the flight from it and yet even within the country of asylum, find themselves vulnerable to further exploitation, a state of insecurity worsened by the stigma and discrimination associated with sexual violence.

¹²⁴"Guidelines for Gender-based Violence Interventions in Humanitarian Settings", *The IASC*, September 2005, <http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402>, Accessed 21 January 2011, p.1

¹²⁵ "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response", *UNHCR*, May 2003, http://www.ec.europa.eu/echo/files/policies/sectoral/health_2003_sgbv_against_refugees_returnees_idps_unhcr.pdf, Accessed 15 October 2010, p.1

¹²⁶ "Guidelines for Gender-based Violence Interventions in Humanitarian Settings", *Op. Cit.*, p.1

¹²⁷ "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response", *Op. Cit.*, p.18

The experiences of SGBV of both Burundian refugee women in Tanzania and Somali refugee women Kenya are overwhelming. “19 percent of 1,575 Burundian women surveyed by the United Nations Population Fund in 2004 had been raped; 40 percent had heard about or had witnessed the rape of a minor”¹²⁸ whilst in Kenya, an orgy of sexual violence occurred in the early 1990s.¹²⁹ In 1993, when the violence was at its peak, there were over 200 reports of rape in the predominantly Somali camp, Dabaab, although according to a rape counsellor, “this was just the tip of the iceberg”, with beatings, sexual assault and rape a daily and nightly occurrence.¹³⁰ This points to one of the characteristic of SGBV, under-reporting, due to fear of self-blame, stigma and reprisals by authorities as well as re-victimization and as such, most available data represents only a very small portion of the actual number of incidents.¹³¹ Another characteristic of this atrocity is its connection to HIV/AIDS, both acting as twin pandemics that feed off and into each other, with violence being both a cause and a consequence where “the fear of violence and stigma associated with HIV acts as a barrier, along with many other factors related to women’s marginalization, to women’s ability to access HIV prevention tools and services, including testing and counselling.”¹³²

In terms of the transmission of the disease, sexual violence increases susceptibility because of its association with increased genital trauma and coital injuries, as well as because of the probable infectiousness of the perpetrator and the likelihood of sexually

¹²⁸ Ward, J., and Marsh, M., “Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources”, *UNFPA Briefing Paper*, June 2006, <http://www.unfpa.org/emergencies/.../docs/finalbrusselsbriefingpaper.pdf>, Accessed 15 October 2010, p.8

¹²⁹ Kagwanja, P.M., “Ethnicity, gender and violence in Kenya”, *Forced Migration Review: Gender and Displacement*, Issue 9, December 2000, <http://www.fmreview.org/FMRpdfs/FMR09/fmr9full.pdf>, Accessed 16 June 2010, p.1

¹³⁰ Ibid.

¹³¹ “Guidelines for Gender-based Violence Interventions in Humanitarian Settings”, *Op. Cit.*, p.4

¹³² “Gender, Sexuality and Violence in the context of HIV and AIDS”, ICRW, <http://www.icrw.org/files/publications/Gender-Sexuality-and-Violence-in-the-context-of-HIV-and-AIDS-a-Call-to-Action.pdf>, Accessed 13 January 2010, p.2

transferred infections (STIs).¹³³ According to Delargy and Klot, factors that are conventionally thought to increase the likelihood of HIV transmission in conflict – including mobility and population displacement, poverty, loss of access to health services and information, unsafe blood transfusion, civil-military interactions, changing family and social structures, demographic impacts, psychological trauma, illicit drug use and STIs are significant but are in fact drivers of HIV vulnerability with the principle risk factor being forced or violent sexual interaction, especially when the physiology of it is taken into consideration.¹³⁴ In terms of epidemiology, risks of transmission are often directly related to sexual violence, including “high-risk sexual encounters for survival, in exchange for food or other relief supplies, to pass borders or to gain certain types of protection. In fact, the term ‘civilian-military interaction’ is often a euphemism for describing situations of sexual violence and exploitation.”¹³⁵ Consequently, the relationship between SGBV and HIV/AIDS and the responses by the state to this are critical.

Unfortunately, very little empirical analysis has been done on this combination of physiological and behavioural combination, with the little emphasis on addressing HIV/AIDS in refugee settings placed on prevention of the disease and not on sexual violence prevention because for the most part, SGBV is treated as part of human rights advocacy, reproductive health or as a gender issue.¹³⁶ Fortunately, various international instruments specifically tackle SGBV against women and girls, including the previously discussed CEDAW and the 1998 Rome Statute of the International Criminal Court which defines rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation or any other form of sexual violence of comparable gravity as a crime against humanity.¹³⁷ Most recently, United Nations Security Council Resolution 1325 (2000) emphasises States’ responsibility to end impunity for crimes against humanity

¹³³ Delargy, P., and Klot, J., “Sexual violence and HIV/AIDS transmission”, *Forced Migration Review: Sexual Violence*, Issue 27, January 2007, <http://www.fmreview.org/FMRpdfs/FMR27/full.pdf>, Accessed 16 January 2010, p.23

¹³⁴ Ibid.

¹³⁵ Ibid.

¹³⁶ Ibid, p.24

¹³⁷ “Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response”, *Op. Cit.*, p.8

and war crimes, including sexual and other forms of violence against women and girls,¹³⁸ but this is problematic when the state is the responsible agent.

In Kenya, government reaction to the mass rapes was dismissive at best, with authorities expressly denying the occurrence, stating that “the reports were meant to attract sympathy for refugees and give the government bad publicity” and that “it was not Kenya’s responsibility to investigate what happened in the camps, it was for Somali’s to sort out themselves”, subsequently declaring the Somali refugees a “UNHCR problem.”¹³⁹ All human rights organizations that investigated the rapes blamed Kenyan authorities for committing some of these atrocities, resulting in the targeting of the Somali refugees for indiscriminate retribution by labelling them *Shifita* or bandits and firing into crowds of refugees after a skirmish between unknown bandits and policemen, evidently a thinly veiled act of revenge which left three dead and six seriously injured.¹⁴⁰ This chain of events reveals the utter defencelessness of the entire refugee community, and the ultimate power and control of the state. Obviously, this case study reveals the gross violation of international law on multiple levels by Kenyan authorities, especially according to the Declaration of Commitment since Article 59 thereof obligates states to “promote the advancement of women and women’s full enjoyment of all human rights” as well as Article 62 which calls for the addressing of activities which place individuals at risk of HIV infection, listing “all types of sexual exploitation” as one of these.¹⁴¹

Apart from revealing the failure of these African host states to uphold their obligations, this study also provides an opportunity to examine the role of UNHCR, as the leader of the international refugee regime, in addressing this critical problem. According to its *Guidelines for Prevention and Response*,

“United Nations, human rights and humanitarian agencies share the responsibility with States to ensure that human rights are protected. As the UN refugee agency, UNHCR is mandated to provide international protection to refugees and seek durable solutions to their problems. Thus, UNHCR and States share the responsibility for ensuring that refugees are protected against sexual and gender-based violence...”

¹³⁸ Ibid.

¹³⁹ Kagwanja, P.M., “Ethnicity, gender and violence in Kenya”, *Op. Cit.*, p.3

¹⁴⁰ Ibid.

¹⁴¹ Articles 59 and 62, The Declaration

...In settings where no actions to prevent and respond to sexual and gender-based violence have been taken, UNHCR should take the lead in co-ordinating and establishing, as part of its core activities, protection and assistance programmes that address this kind of violence.”¹⁴²

Unfortunately, this situation revealed the severe shortcomings of the agency. While it attempted to improve security in camps by contributing to the building of police stations and established the Women Victims of Violence programme with rape counsellors, it was disturbingly averse to filing civil suits against the perpetrators or initiating private criminal prosecution on behalf of refugees.¹⁴³ The reason for this could be attributed to the agency being wary of antagonizing the already hostile Kenyan government, or perhaps more disturbingly, out of fear for jeopardizing its programmes in the country.¹⁴⁴ Consequently, this exposes the multiple levels of vulnerability experienced by refugee women: vulnerable to HIV/AIDS because of their gender and their refugee status but also because of the host state’s disregard for their human rights as well as UNHCR prioritizing of its own agendas above their individual security.

Ironically, the agency attributes “the causes of SGBV to be largely rooted in unequal power relations which perpetuate and condone violence”¹⁴⁵, a statement which both it and host states have proven to be sadly true. It lists other causes as design and social structure of camp, including the lack of police protection and UNHCR/NGO presence¹⁴⁶, while HIVInSite states that military presence has been shown to facilitate STI transmission,¹⁴⁷ hinting at the aforementioned civilian-military interaction’. This calls for a return to the exploration of the factors that increase the vulnerability by acting as drivers of violent sexual interaction, which acts as the principle risk factor of vulnerability of HIV/AIDS transmission for refugee women.

¹⁴² “Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response”, Op. Cit., p.9

¹⁴³ Kagwanja, P.M., “Ethnicity, gender and violence in Kenya”, Op. Cit., p.4

¹⁴⁴ Ibid.

¹⁴⁵ “Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response”, Op. Cit., p.11

¹⁴⁶ Ibid., p.22

¹⁴⁷ McGinn, T., et. al., “Forced Migration and Transmission of HIV and Other Sexually Transmitted Infections: Policy and Programmatic Responses”, November 2001, HIVInSite, <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-08>, Accessed 26 August 2010

4.4. THE ARMED FORCES

According to Seckinelgin, H., Bigirumwami, J., and Morris, J., in “Gendered violence and HIV in Burundi”, the connection between the military and the spread of HIV/AIDS amongst civilian populations, refugee or local, is overrated because it simplistically relies on a single causal link, positing that the ‘military’ implies a male gender position while the use of ‘general population’ suggests a female gender position, which disregards the intricate links between the creation of gender vulnerabilities.¹⁴⁸ That said, it is irrefutable that the armed forces act as vectors of the disease, with some estimates suggesting that HIV prevalence in Africa is higher amongst regular forces and insurgents than among refugees.¹⁴⁹ According to UNAIDS, “U.N. estimates put the continent-wide HIV prevalence rate in Africa at 9.5% in the general population, but 27% among the armed forces.”¹⁵⁰ In addition, recent analysis showed that military personnel in 21 African countries have almost twice the chance of being HIV infected as civilian populations.¹⁵¹ There are numerous reasons to explain these high prevalence levels, ranging from military culture glorifying violent and risky behaviour, leading to risky sexual behaviour; most military personnel or members of the police forces being young men, proven to be a high risk group; as well as this group often being better paid than the local population, thereby attracting the commercial sex industry.¹⁵²

During conflict, armed forces often use sexual violence and rape as a weapon of war but in post-conflict settings, this is often perpetuated due to the lack of protection of refugee, women in particular. “Militaries, militias, men carrying arms, government and non-state actors, neighbours, trusted leaders and men in positions of power have all

¹⁴⁸ Seckinelgin, H., Bigirumwami, J., and Morris, J., “Gendered violence and HIV in Burundi”, *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010, <http://www.fmreview.org/Aids.pdf>, Accessed 12 January 2010, p.18

¹⁴⁹ Iqbal, Z. And Zorn, C., “Violent Conflict and the Spread of HIV/AIDS in Africa”, *The Journal of Politics*, Vol. 72, No. 1, January 2010, p.150

¹⁵⁰ Ibid.

¹⁵¹ Hanson, B., et. al., “Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations”, *AIDS*, 2008, Vol 22., p.99

¹⁵² McGinn, T., et. al., “Forced Migration and Transmission of HIV and Other Sexually Transmitted Infections: Policy and Programmatic Responses”, *Op. Cit.*

perpetrated violence against women and girls in times of conflict and displacement.”¹⁵³ The existing vulnerability of refugee women coupled with the high prevalence levels amongst members of the armed forces, who often perpetrate sexual violence against them, creates a situation where women are treated as, and made to feel, dispensable. As a result, they are forced to engage in transactional sex, a direct result of the breakdown of social cohesion characteristic of refugee situations as well as poverty and powerlessness in the face of more powerful figures demanding sexual favours.¹⁵⁴ In addition, women fearful of, or having been subjected to, sexual violence, may attempt to seek protection and assistance from members of the armed forces, rather than risk repeated violations by many men.¹⁵⁵ This precipitates refugee women becoming dull to the dangers of the entering the sex trade because of their histories of victimization, reinforcing this dangerous cycle of civilian-military-sex industry, which increases their vulnerability to HIV/AIDS.

While both Kenya and Tanzania’s national plans have only recently incorporated HIV prevention efforts for police and other law enforcement services, these responses have been ineffective for two reasons. Firstly, governments in general are usually unwilling to publish HIV prevalence data for their military forces, possibly because of state security concerns,¹⁵⁶ thus information on the compliance of these host states with international obligation which would pertain to the armed forces, is very difficult to come by. Secondly, their responses have been primarily driven by concerns about the effectiveness of the forces since, “HIV and AIDS can threaten the operational capability of armies primarily at the tactical level of operations and can affect combat

¹⁵³ Egeland, J., “International Responsibilities”, *Forced Migration Review: Sexual Violence*, Issue 27, January 2007, <http://www.fmreview.org/FMRpdfs/FMR27/full.pdf>, Accessed 16 January 2010, p.8

¹⁵⁴ Seckinelgin, H., Bigirumwami, J., and Morris, J., “Gendered violence and HIV in Burundi”, *Op. Cit.*, p.11

¹⁵⁵ “Addressing the Needs of Women Affected by Armed Conflict”, *An ICRC Guidance Document*, March 2004, http://www.unicef.org/emerg/files/ICRC_women_war.pdf, Accessed 26 January 2010, p.26

¹⁵⁶ Hanson, B., et. al., “Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations”, *Op. Cit.*, p.99

effectiveness, unit cohesion, morale and discipline.”¹⁵⁷ While this is in accordance with obligations from the Declaration, namely, Article 77 which calls for national strategies to address the spread of HIV among national defence forces,¹⁵⁸ this once more neglects the impact that the HIV/AIDS-armed forces connection has on refugee women and their vulnerability to the disease.

Worse still, even humanitarian and peacekeeping staffs – military and civilian alike – have been responsible for acts of sexual violence and exploitation. From 2004 to 2007 almost 200 UN peacekeepers were disciplined for sexual offences, but none were prosecuted due to insufficient impunity for perpetrators as accountability is lost between the overseeing forces of the UN, the leaders of the militaries and the officials of the host countries.¹⁵⁹ The disregard for the gravity of this problem was evident when Special Representative to the Secretary-General, Yasushi Akashi, shrugged off allegations of sexual exploitation by UN workers with the statement ‘boys will be boys.’¹⁶⁰ The disinterest in this factor or driver of vulnerability to HIV/AIDS transmission for refugee women by both the host states and the international community, further complicate analysis of other drivers of vulnerability, such as the structure of the refugee camps, given that the presence of the armed forces or humanitarian works to improve the protection of these women, is evidently not always a positive development.

4.5. CAMP STRUCTURE

According to UNHCR, there is a pattern of reduced HIV rates within long-term post-emergency refugee camps, i.e. protracted refugee settings, as revealed by a study of pregnant women in more than 20 refugee camps, including those within Kenya and

¹⁵⁷ De Waal, A., et. al. “HIV/AIDS, security and conflict: new realities, new responses”, *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010, <http://www.fmreview.org/Aids.pdf>, Accessed 31 January 2010, p.6

¹⁵⁸ Article 77, “Declaration of Commitment on HIV/AIDS: five years later”, Report of the Secretary-General, *UNGASS Sixtieth Session*, 24 March 2006

¹⁵⁹ Hanson, B., et. al., “Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations”, *Op. Cit.*, p.99

¹⁶⁰ Ibid.

Tanzania.¹⁶¹ That said, the design of refugee camps more often than not increase security risks for women because of poor facilities and overcrowding e.g. the Dabaab camp in Kenya which was initially meant to hold 90 000 refugees but is now home to almost 300 000, with a constant flow of new refugees.¹⁶² UNHCR acknowledges this as problematic, noting that the design of the camps as well as the nature thereof, including overcrowding and multi-household dwellings which afford refugee women little privacy, is a risk factor comparable to the seriousness of the lack of UNHCR/NGO protection or security patrols.¹⁶³ Women are also made vulnerable by the distances between living spaces and water or firewood collection areas, with almost 90 percent of rapes amongst Somali refugees in Kenya having occurred under these circumstances,¹⁶⁴ a situation compounded by the harvesting of all trees in the region to use for firewood turning the camps into deserts.¹⁶⁵ In addition, in a 1996 survey of Burundian refugee women in Tanzania, more than two thirds reported being raped after displacement, either inside or close to the camp, testament to the relationship between ill-considered camp design and violence against women.¹⁶⁶

As with the other factors of vulnerability, the responses by the host states to this have been negligible at best. In response to the overcrowding of the camps, the Kenyan government officially closed its border with Somalia in response to the influx of refugees after the Ethiopian intervention in Southern Somalia,¹⁶⁷ subsequently worsening the situation within the camps as authorities avoid improving the camps for fear of the permanence that such action would result in. Similarly, the Tanzanian

¹⁶¹ Roberts, B., HIV/AIDS, Conflict and Forced Migration, *Op. Cit.*, p.8

¹⁶² "Somali camps 'Unfit for Humans'", *BBC News*, 3 September 2009, <http://www.news.bbc.co.uk/2/hi/africa/8235089.stm>, Accessed 19 January 2010

¹⁶³ "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response", *Op. Cit.*

¹⁶⁴ Ward, J., and Marsh, M., "Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources", *Op. Cit.*, p. 7

¹⁶⁵ Mwangi, B., "Harsh life at the Daadab, Kenya Refugee Camp", http://www.wunrn.com/news/2007/01_07/01_22_07/012707_kenya2.htm, Accessed 31 January 2011

¹⁶⁶ Ward, J., and Marsh, M., "Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources", *Op. Cit.*, p.8

¹⁶⁷ "From Horror to Hopelessness: Kenya's Forgotten Somali Refugee Crisis", *Op. Cit.*

government's strategy of creating small 'temporary' camps after the influx of refugees in the 1990's situated close to the border to improve the ease of repatriation¹⁶⁸ is problematic for the safety of refugee women because of the proximity to armed forces, i.e. policemen patrolling the border, and the subsequent institutionalization of sexual abuse and sexual favours. While practical deterrent actions in and around the camp such as patrolling firewood collection routes, improving lighting around the camp can be effective and have been attempted by UNHCR such as the previously mentioned Women Victims of Violence project, these are inadequate in number and often grossly underfunded. The combination of insecurity brought about by the camp and the lack of adequate income and access to resources acts as a potent driver as this reinforces the cycle of sexual exploitation and prostitution, which in turn adversely influences the propensity of refugee women with the camps to become infected. At this point, it is necessary to examine the last factor of vulnerability, access to resources and opportunities of refugee women.

4.6. ACCESS TO RESOURCES AND OPPORTUNITIES

According to Peter Piot, Director of UNAIDS, at the launch of the Global Coalition on Women and AIDS, in London on 2 February 2004, "All too often, HIV prevention is failing women and girls."¹⁶⁹ Unfortunately, it is not only prevention which fails refugee women, but lack of access to treatment and resources or initiatives to mitigate the impact of the epidemic are also increasing their vulnerability because the disease is fuelled by existing inequalities. A study by Philip Setel in Tanzania revealed that a breakdown in social values has contributed to the rise in sexual violence because of the strains of the economic situation,¹⁷⁰ evidence enough of the interplay between all the factors of vulnerability and HIV/AIDS prevalence. The differentials between refugee women and men in healthcare access impacts greatly on the preventative options available to refugee women as well as care for those living with the disease, especially

¹⁶⁸ "Refugee Services Department", Tanzania Ministry of Home Affairs, , http://www.moha.go.tz/index.php?option=com_content&view=article&id=46&Itemid=14, Accessed 31 January 2011

¹⁶⁹ Seeley, J., Grellier, R. and Barnett, T., "Gender and HIV/AIDS impact mitigation in sub-Saharan Africa — recognising the constraints", *Journal of Social Aspects of HIV/AIDS*, Vol. 1, No. 2, August 2004, p.88

¹⁷⁰ Ibid, p.94

with regard to access to antiretroviral treatment, however this is a hotly debated topic within the study of HIV/AIDS internationally, a debate which is beyond the remit of this paper. Thus, in dealing with access to resources, the socio-economic factors of poverty, migration and opportunities will be addressed.

Economic factors are intrinsic to the HIV epidemic, with a wealth of literature and empirical evidence revealing that the disease disproportionately affects less developed countries and resource-poor communities, of which refugees in protracted situations are a prime example. The factors of poverty, migration, and lack of access to productive resources, education and training stimulate risky behaviours that are responsible for HIV transmission, create obstacles to prevention, and impede efforts to cope with the impact of the epidemic.¹⁷¹ According to the UN Secretary General's Task Force on HIV/AIDS in Southern Arica

"Poverty and HIV infection are deeply intertwined. As the burden of caring for the sick, the dying and the orphaned forces millions of African women deeper into poverty and batters their energy and self-esteem, so it increases the pressure to resort to high risk 'transactional' sex – sex in exchange for money or goods – or sex with older 'sugar daddies' who offer the illusion of material security. And as more and more women and girls take to the streets as their only means of survival, the need to confront gender inequality becomes inescapable."¹⁷²

Poverty increases susceptibility to contracting HIV through several channels, including increased migration to urban areas since research shows that rural-to-urban migration, which although heavily regulated in the refugee context, occurs often as the lack of economic opportunity in the camps force refugees to illegally migrate to urban areas, increases vulnerability to HIV/AIDS. This is because migrant men and women have been found to be more likely to engage in risky sexual behaviour than non-migrants due to such factors as spousal and partner separation, post-migration exposure to new social and economic environments, economic marginalization and social isolation which further fuels the epidemic when migrants return home and re-establish sexual relations with their partners.¹⁷³ Other ways that poverty negatively affects refugee women

¹⁷¹ Banerjee, S. and Sharma, U., "Gender, Sexuality, Rights and HIV: An overview for community sector organizations", International Council of AIDS Service Organizations, Op. Cit., p.18

¹⁷² Ibid.

¹⁷³ Ibid, p.19

include the conditions where sexual activity may take place, i.e. in overcrowded spaces where negotiating responsible behaviour is not possible as well as placing them under pressure to exchange sex for material favours to ensure the survival of themselves and their families.¹⁷⁴

For almost all refugee women in protracted states of displacement, their access to resources or economic opportunities, are almost non-existent. Thus, lack of access to land, property and income, results in transactional sex, reinforcing the cycle of vulnerability. This connection between the disease and the socio-economic factors discussed is recognized by the declaration which states

“Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner.”¹⁷⁵

“Yet another important factor is education; over and above the generalized effects of wealth and development, education plays a key role in HIV/AIDS prevention by enabling people at risk of acquiring the disease to obtain relevant information and resources.”¹⁷⁶ This is because, educated men and women can make more informed decisions regarding their sexual behaviour, improves economic opportunity as well as positively influences men’s sexual behaviour, as revealed by a 2003 study by Ukwuani, Tsui, and Suchindran in Uganda and Tanzania which found a positive relationship between education and condom use among men.¹⁷⁷ Unfortunately, the literature available on the connection between restrictions on women’s access to educational and vocational training which would lessen their susceptibility in numerous ways, does not always apply to refugee women due primarily to their refugee status preventing them access to either labour markets within their host state or education opportunities. As such, it is necessary to examine the refugee policies of the host states so as to

¹⁷⁴ Ibid.

¹⁷⁵ Article 11, The Declaration, Op.Cit.

¹⁷⁶ Iqbal, Z. And Zorn, C., “Violent Conflict and the Spread of HIV/AIDS in Africa”, Op.Cit., p.153

understand the socio-economic restrictions placed on refugees as well as any responses to improve these by the host state and the international community.

Access to international assistance is critical to the development of refugee women as well the protection of their basic human rights, and one of the surest ways of attaining it is by active participation by the recipients of it in both the decision-making process and the execution of resultant programmes and projects and yet, popular participation has lagged behind as an acceptable part of refugee programme, particularly participation by women.¹⁷⁸ Constraints on refugee participation include reluctance of the part of the host state for fear of losing control or encouraging permanence, barriers deriving from cultural values as well as absence of respected leaders from the refugee populations themselves.¹⁷⁹ When access to international assistance of Somali women in Kenyan refugee camps is examined, especially assistance from UNHCR, it is revealed that commonly-held views asserting that women belong in the private sphere has contributed to the lack of female representation in decision-making processes, with forces of subordination, domination, and exclusion of refugee women located in both the household and the political and power structures of the camp, both of which reinforce and strengthen the patriarchal tendency of the community and go unrecognized by refugee assistance programmes.¹⁸⁰

More importantly, the previously mentioned flagrant violation of international law, both customary and legislation i.e. The UNHCR 1951 Convention on the Status of Refugees, by Kenyan authorities in closing its border with Somalia has directly prevented access to international assistance by refugee women. The actions of the Kenyan government have resulted in the forced closing of a UNHCR-run registration centre as well as its transit centre close to the border¹⁸¹ which has severely weakened the situation of refugee women in the camps. The lack of adequate assistance from Kenyan authorities is reiterated by their failure to make good their promise to make more land available to relieve the congestion in the chronically overcrowded camps near Dabaab in north-

¹⁷⁷ Ibid.

¹⁷⁸ Martin, S.F., *Refugee Women*, Women and World Development Series, Zed Books, London, 1991, p.10

¹⁷⁹ Ibid, p.11

¹⁸⁰ Callamard, A., "Refugee Women: a gendered and political analysis of the refugee experience" in Ager, A., (ed.): *Refugees*, Pinter, London, 1999, p.200

¹⁸¹ Ibid.

eastern Kenya which has left tens of thousands with no option but to squeeze into the bursting camps, with little or no access to any international assistance because of lengthy asylum determination procedures and severe resource shortages of the UNHCR and other aid agencies.¹⁸²

Because the United Republic of Tanzania has hosted the largest refugee population in Africa for decades, the growing phenomenon of irregular and mixed population flows has also revealed itself as a constraint because the constant flow of people seeking asylum has often detracted from the plight of the older Burundian refugee group. Thus, Burundian refugees are doubly disadvantaged because their needs are always less pressing than newer refugees, and the pursuit of solutions, which include the ground-breaking naturalization and local integration programme for the 1972 Burundian refugees in the Old Settlements,¹⁸³ has led to a neglect of those Burundians who do not qualify for naturalization but cannot return home and thus are forced into a form of camp-life limbo.

This is exacerbated by Tanzania having severely restricted refugees' freedom of movement for about a decade, requiring that they reside in camps and making it extremely difficult for them to find employment or other means of livelihood because of the state's 1998 Refugee Act, which confines refugees to designated camp areas and criminalizes any violation of the law thus refugees who travel beyond a 4km radius of the camps are subject to arrest and imprisonment.¹⁸⁴ A refugee from Burundi who was granted asylum by UNHCR describes life in the Tanzanian camps as unbearable, stating that "Our freedom was denied. We were kept like cattle, like cows on a farm. We were denied the right to work or to show what we were capable of" and soon fled for the urban setting of Dar es Salaam¹⁸⁵, to rather live a clandestine life, than an oppressed one. Thus, Tanzania, which hosts the largest population of refugees in Africa, is denying

¹⁸² "Kenya: Relieve Somali Refugee Crisis", Human Rights Watch, 5 June 2009, <http://www.hrw.org/en/news/2009/06/05/kenya-relieve-somali-refugee-crisis>, Accessed 13 October 2010

¹⁸³ Ibid.

¹⁸⁴ Chen, G., "Unseen, Unheard, Unaided: Urban Refugees in Dar es Salaam, Tanzania", <http://www.refugees.org/article.aspx?id=1173>, Accessed 8 October 2010

¹⁸⁵ Ibid.

refugees even the most basic rights afforded under international law; that refugees shall have the “right to choose their place of residence and to move freely within its territory” subject to the policies generally applicable to foreign nationals.¹⁸⁶ In addition, by forcing refugees to migrate illegally, the host state is contributing to their susceptibility of HIV infection, because as discussed earlier, the conditions of forced migration, be it due to conflict or surreptitious migration to urban areas in search of improved living conditions, increase the risk of infection by means of risky sexual behaviour, sexual violence etc. Consequently, the problems associated with Somali refugee women in Kenya are duplicated in this situation: overcrowding and underfunded camps exacerbating shortages of shelter, water, food and healthcare, which are felt most strongly by women, who have little access to international aid because of their insecure position.

The importance of access to international assistance is most evident when looking at the critical issue of access to healthcare resources for refugee women. While the lack of healthcare facilities in refugee camp settings has widespread implications for refugee populations as a whole, given the often unsanitary camp conditions, it is women and girls who suffer most from inadequate access to proper healthcare. Healthcare is critical because primary health care for women and girls is a prerequisite to improving the health of the entire family and community. Also, the additional burdens placed upon women during conflict, such as the economic strain of becoming the head of their household, due to death of male breadwinners, coupled with the emotional strain of loss of loved ones, may exert an adverse impact on their health,¹⁸⁷ which is dangerous when considering that a woman incapacitated by ill health translates into whole families put at risk. Thus, the pivotal role played by women in maintaining their own health and welfare, as well as that of their family and community, must be supported and utilized to its full potential.¹⁸⁸ Unfortunately, constraints to this include logistical problems such as the absence of female health practitioners, and the impermanence of aid centres such as UNHCR centres around the Dadaab camps which closed after the border was closed,

¹⁸⁶ Ibid.

¹⁸⁷ “Addressing Needs of Women Affected by Armed Conflict”, An ICRC Guidance Document, March 2004, [http://www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/p0840/\\$File/ICRC_002_0840_WOMEN_GUIDANCE.PDF](http://www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/p0840/$File/ICRC_002_0840_WOMEN_GUIDANCE.PDF), Accessed 8 May 2010

¹⁸⁸ Ibid.

as well the forced temporariness of Tanzanian centres due to the government's wish to resolve its refugee issue, which consequently forces women to travel longer distances to receive aid. This in turn makes women more susceptible to increased abuse from authorities who determine the extent of the mobility from camps to urbanized areas, where healthcare is more accessible.

Basic healthcare needs include personal hygiene, safe birthing conditions, pre- and post-natal care, family planning and critically, prevention and treatment of sexually transmitted diseases.¹⁸⁹ Some organizations, such as the UNHCR as well as other Non-Governmental Organizations (NGOs) such as the Red Cross, provide basic healthcare for women in refugee situations but in a survey conducted by *Saving Women's Lives* of 81 NGOs working with refugees and Internally Displaced Persons (IDPs), only 38 supplied reproductive health services and less than 10 had gender specific policies or guidelines on providing reproductive health services.¹⁹⁰ Understanding the healthcare problems of women refugees demands an exploration of what exactly the host states and the international refugee regime is doing to address their needs, followed by the state's reaction and role therein.

The movement to adequately address reproductive health in refugee settings can be traced to reports done by the Women's Commission for Refugee Women and Children, a nongovernmental advocacy group, as well as by The National Council for International Health's annual meeting in 1994 which both revealed that historically, healthcare for refugees and IDPs followed the relief-model, providing only those medical services considered to be "life-saving", regardless of the stability of the setting and subsequently, neglecting reproductive health services that also save lives.¹⁹¹ In short, the refugee regime was failing women in this area, leaving them helpless and at the mercy of the host state, which often employs indiscriminate policies at best. This reveals the doubled vulnerability of refugee women; insufficient access to adequate healthcare because of their refugee status and then if fortunate enough to receive healthcare, it doesn't

¹⁸⁹ Torres, A. B., "FMO Thematic Guide: Gender and Forced Migration", http://www.forcedmigration.org/678_gender_3241/thematicfmo/231, Accessed 11 October 2010

¹⁹⁰ Ibid.

¹⁹¹ McGinn, T. et. al., "Forced Migration and Transmission of HIV and other Sexually transmitted Infections: Policy and Programmatic Responses", *Op. Cit.*

sufficiently address their needs. While it is acknowledged that many states do give medicine to refugees, particularly ARVS, this is often insufficient but more importantly, falls under the second response to HIV/AIDS, namely, treatment and care, and as such does not adequately protect them from infection because measures to prevent infection are insufficient.

The failure of refugee aid agencies has contributed to the inadequate protection of the basic human rights of refugee women, i.e. the right to medical assistance as enshrined in international humanitarian law¹⁹², which has adverse effects on their development. This can be remedied by once more improving the participation of refugee women in the planning and implementation of healthcare services, in addition to ensuring an equitable distribution of outsourced female healthcare workers, improving logistical aspects of healthcare provision as well as increasing security to and around healthcare facilities.

Fortunately, there has been much progress in this field, as revealed by such developments as the establishment in 1995 of the Reproductive Health for Refugees (RHR) Consortium as well as the publishing of the InterAgency Field Manual on Reproductive Health in Refugee Situations, which is a basic guide to support the delivery of quality health services and has been endorsed by over 30 relief and reproductive health agencies.¹⁹³ Nonetheless, the onus remains on the host state to either implement or allow for the implementation of such guides. This is because the factors that underlie conflict, particularly those in high HIV prevalence areas, are similar to those that exacerbate serious health problems, such as HIV transmission i.e. poverty, powerlessness, social instability and marginalization¹⁹⁴ and as such, should, but seldom do, receive as much attention as conflict does, because HIV/AIDS constitutes as great a threat to human security. The reality that these factors are even more pronounced amongst refugee populations needs to be recognized, especially because they affect women refugees more so than male refugees.

The term “human security” can be understood as safety from both violent and non-violent threats and entails taking preventative measures to reduce vulnerability and

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

minimise risk as well as taking remedial action where prevention has failed. The measures taken to prevent vulnerability to HIV in both Kenya and Tanzania, in the context of the socio-economic conditions that increase risk to infection, are almost non-existent and the same can be said for any remedial action. This is because of common assumptions in both states that refugees are to be blamed for the prevalence of the virus, and yet this assumption is not supported by data. In fact, since 2002 UNHCR and its partners have been conducting research in refugee camps in Kenya, Rwanda, Sudan and Tanzania, and in both Kenya and Tanzania, refugees had lower HIV-prevalence rates than their surrounding host communities.¹⁹⁵ Infection rates may have fallen in both of these countries, due to increased education interventions, but the fact that these are not directed at refugees is problematic. Not because refugees are afflicted by drastically higher prevalence levels, but simply because the abundance of risk-increasing factors which characterize the existence of refugee women demand more attention so as to mitigate their impact.

Ultimately, countries of asylum are responsible for the protection and well-being of all people living on their soil, including refugees and yet, the fact that refugees are excluded from the host countries' HIV/AIDS National Strategic Plans continues to reveal itself as reinforcing their vulnerability HIV/AIDS because their needs are constantly ignored, resulting in the drivers of vulnerability; sexual violence, breakdown of social systems, the armed forces, inadequate camp structures and access to resources and opportunities continuing to reinforce one another as well as being compounded by inadequate responses by the host state and the international refugee regime.

¹⁹⁵ Spiegel, P.B., "HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action", *Disasters*, 2004, 28(3), pp. 326

CHAPTER FIVE: CONSTRAINTS TO STATE COMPLIANCE

While the onus is on states to ensure their compliance with the Declaration of Commitment, it should be noted that challenges do exist which limit their capacity to fulfil their international obligations. According to a report commissioned by Save the Children, the “lack of international funding is the single largest obstacle to reducing the spread of HIV in conflict-affected situations. Without a greatly enhanced response and funding, conflict-affected countries will not meet their UN commitments on HIV/AIDS to meet the basic needs and provide prevention, care and support, to alleviate the impact.”¹⁹⁶ While host states may not directly experience conflict, both Kenya and Tanzania undoubtedly fall under this category of conflict-affected countries because of the presence of refugees from conflict areas, but this presence brings with it more challenges due to the burden placed on the host states’ infrastructure, local population and resources. As such, this chapter seeks to explore the challenges faced by host states which could possibly explain the degree of their compliance; first examining state-induced constraints, followed by constraints brought about by the international refugee regime as a whole.

5.1. STATE-INDUCED CHALLENGES

The overwhelming nature of the HIV/AIDS pandemic, more specifically its spread and the inability of states to alleviate the impact thereof, has revealed the limited capacity of many governments to adequately address it, failing to protect and provide services to their own populations, thus the difficulty faced by host governments must be acknowledged. That said, general unwillingness to address the drivers of the disease within refugee populations by host states often acts as a major constraint to state action. This is due to the confusion as to who exactly is responsible for the reproductive health of refugees, as mentioned earlier, most host states do not view refugees as falling within the scope of their national AIDS programmes due to their refugee status. Rudd Lubbers, the High Commissioner for Refugees notes that “host countries should stop excluding refugees from their AIDS programmes. It is highly discriminatory and totally

¹⁹⁶ Roberts, B., “HIV/AIDS, Conflict and Forced Migration”, *Op. Cit.*, p.20

counter-productive... these individuals have been neglected for too long”¹⁹⁷ however; the impact of state neglect on refugees has already been discussed; it is the reasons for this that now need examination.

Firstly, confusion arises from the different stages of conflict, identified as emergency, post-emergency and reconstruction. Conflict may be understood as the actual waging of war between armed parties, post-conflict the stage during which mediation attempts progress to resolve the discord and reconstruction the period during which the state in which the conflict has occurred attempts to bounce back. Refugees fall under the reconstruction stage as it usually within this that conventional solutions to refugees occur i.e. repatriation or resettlement. The confusion is that on paper, responsibility for refugees potentially falls on the country of origin as most hope for a quick resolution of the refugee problem. Unfortunately, this is rarely the case, with the average stay of refugees in camps having reached 17 years worldwide,¹⁹⁸ which is evidently anything but quick. With extensive stays in host countries, coupled with countries of origin which are often unsuitable for return and consequently unable to provide for its displaced nationals, the responsibility falls on the host state. UNHCR states that

“protracted refugee situations stem from political impasses. They are not inevitable, but are rather the result of political action and inaction, both in the country of origin (the persecution and violence that led to flight) and in the country of asylum. They endure because of ongoing problems in the country of origin, and stagnate and become protracted as a result of responses to refugee inflows, typically involving restrictions on refugee movement and employment possibilities, and confinement to camps.”¹⁹⁹

The health services in host states may already be strained, especially in resource-poor states, which makes addressing the needs of refugees difficult, irrespective of there being any willingness to do so. Poor infrastructure and human resource capacity also acts a constraint on state action. Furthermore, the fear of refugees being integrated into the local population dissuades states from creating refugee-specific HIV/AIDS programs

¹⁹⁷ Lubbers, R., “UNHCR Reaffirms Commitments to HIV/AIDS”, UNHCR News Story, 1 December 2003a, <http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=search>

¹⁹⁸ Hanson, B., et. al., “Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations”, *Op. Cit.*, p.98

¹⁹⁹ Loescher, G. and Milner, J., “Understanding the Challenge”, *Protracted Displacement, Forced Migration Review*, Issue 33, September 2009, p.9

because of the implied permanence thereof. In addition, sovereignty concerns prevent states from cooperating with NGOs in a coordinated manner, with most choosing instead to rely on UNHCR to look after the welfare of refugees so as to prevent meddling within their HIV/AIDS policies and programmes, which would probably result in calls for more inclusion of refugees. This points to the fundamental state-induced constraint: exclusion of refugees from national HIV/AIDS strategic plans. This results in “an imbalance of power in favour of [government], which is talking only on behalf of government”, where agencies, such as humanitarian NGOs, which could potentially assist with the protection of refugees from the disease, and by extension assist governments in fulfilling their obligations under the Declaration, being marginalized from the main sources of AIDS funding.²⁰⁰ This means that even when there is available international funding for HIV/AIDS, the inadequate attention given to prevention of the disease amongst refugee by the host state results in them not benefitting. A prime example of this is Tanzania’s three accepted Global Fund and Multi-country HIV/AIDS Programs which total close to US\$ 110 000 000 in approved funds, and yet, do not include any specific activities for displaced persons,²⁰¹ focusing instead on treatment and care initiatives.

5.2. EXTERNALLY INDUCED CONSTRAINTS

Host states are however equally constrained by the nature of the HIV/AIDS regime. The excessive bureaucratic requirements needed to apply for, secure and receive funding by host states are often a disincentive because of frustration with procedural demands when dealing with conflicted-affected populations.²⁰² This coupled with state unwillingness to cooperate with UN agencies and NGOs denies civil society the opportunity to participate in changing the course of the pandemic within refugee communities, even when the extensive expertise adept at negotiating the labyrinth of international funding procedures is present. This is worrying because UNAIDS specifically includes civil society as a significant contributor to the development and

²⁰⁰ Roberts, B., HIV/AIDS, Conflict and Forced Migration, Op. Cit., p.22

²⁰¹ Ibid.

²⁰² Hanson, B., et. al., “Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations”, Op. Cit., p.98

implementation of national-level HIV/AIDS policies and strategies, equating the importance of civil society involvement with that of political support and the upholding of human rights.²⁰³

As alluded to, funding for refugees, both from donor countries and from funding agencies, also presents a major challenge to addressing the disease amongst refugees.

In terms of individual donor countries or even donor groups, donor fatigue plays a big role in the neglect of refugees, typifying the international response to the frequency of conflict and resultant displacement of people as well as the seemingly slow capacity of host states to adequately deal with the refugee problem. In addition, donor groups often maintain a specific scope of funding, focusing on specific fields or interests which complicates the provision of funds in conflict settings because of the three phases spanning a large spectrum of fields and interests which are often beyond the scope of one group.²⁰⁴ Donors are often willing to provide funding at the onset of an emergency, but this enthusiasm more often than not runs out after 1 or 2 years, meaning that only emergency situations are addressed and long-drawn out post-emergency stages, i.e. protracted refugee situations, are neglected due to donor fatigue as revealed by the reluctance of donors to support programmes for refugees who have been living in camps for over a decade.²⁰⁵ Also, programme consistency acts as a possible constraint because even when funds are secured and distributed, the inconsistency of displacement can result in programmatic gaps for example the provision of antiretroviral drugs may be provided in host countries but not once refugees have been resettled or repatriated²⁰⁶ thus refugees faced with the prospect of inferior health services may not want to leave the host state, which in turn dissuades the state from allowing the provision of these services.

Also, international multi-lateral funding agencies tend to neglect the needs of refugees almost as much as states do. The Global Health Fund for AIDS, Tuberculosis and Malaria

²⁰³ "Monitoring the Declaration of Commitment on HIV/AIDS: GUIDELINES ON CONSTRUCTION OF CORE INDICATORS, UNGASS, July 2005

²⁰⁴ Hanson, B., et. al., "Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations", Op. Cit., p.97

²⁰⁵ Ibid.

²⁰⁶ Ibid.

(GFATM) has been criticized extensively for dispersing aid to countries whose proposals for funding did not include refugees, or if they did, did not specifically provide details on how they would be addressed, with the same criticisms being directed at the US administration's president's Emergency Plan for AIDS Relief (PEPFAR).²⁰⁷ Evidently, "the development of integrated HIV/AIDS strategies would be given an enormous boost if donor countries would loosen current restrictions on funding so money can be used more flexibly to provide HIV/AIDS programmes to both refugees and local communities."²⁰⁸ It is acknowledged however that the GFATM can only fund proposals that it has been presented with, not dictate the content of those proposals despite the authority to reject and make recommendations concerning the proposed programmes. As such, this points once more to the dominance of the host state in determining the degree of attention that refugees receive, in the context of international funding for HIV/AIDS and the programmes addressing it.

It should be noted however that donors and development agencies have tended to neglect the post-conflict phase on a more fundamental level too, due in part to a common but ill-founded belief that the end of conflict signals a time of social reconciliation, reinvestment in social development by national governments and an economic recovery that automatically benefits the general population, but as shown, refugees seldom are included in considerations regarding the general population.²⁰⁹

There is often an unsubstantiated distinction made between humanitarian relief and development assistance which adversely affects refugees because it is simply too simplistic.²¹⁰ Preventing HIV/AIDS amongst refugees and especially protecting refugee women is both a humanitarian imperative as well as a development concern. Unfortunately, it often falls within the chasm that is the debate between humanitarianism and development. Thus, not only are host states inadequately addressing the pandemic amongst refugees, within the context of the socio-economic factors that make them vulnerable to infection, but humanitarian agencies too, often

²⁰⁷ Roberts, B., HIV/AIDS, Conflict and Forced Migration, *Op. Cit.*, p.20

²⁰⁸ Ibid.

²⁰⁹ Carballo, M. et. al., "Post-conflict transition and HIV ", *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010 p.20

²¹⁰ Ibid.

viewing it as the work of specialist development or HIV/AIDS practitioners, whilst development agencies commonly see any services for displaced persons, not to mention those in protracted states, as purely humanitarian.²¹¹ It is thus evident that refugee women in protracted states of displacement are being ignored on numerous levels; by the host state; international refugee regime as well as the international donor community which has serious implications for the spread of HIV/AIDS as well as the future of it and how the international community as a whole addresses it.

²¹¹ Ibid.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

This research has attempted to provide an understanding of the synergy between gender, protracted displacement and HIV/AIDS by employing a state-centric approach to understanding the realities of the existence of refugee women in protracted situations of displacement. The role played by states in the ensuring of their security was analysed in the context of HIV/AIDS as a threat to their human security. This was done by examining the states' fulfilment of their international obligations, particularly under the 2001 UNGASS Declaration of Commitment on HIV/AIDS, as a means to measure the effectiveness of their responses in dealing with the HIV/AIDS pandemic amongst this forgotten majority. It was discerned that refugees in protracted states of displacement are marginalized by the host state due to their legal status as refugees but worse still because they are neglected within the host states' National Strategic Plans on HIV/AIDS. This is in violation of host states' commitment under international refugee law, according the 1951 *Convention Relating to the Status of Refugees* as well as international human rights law, according to the Universal Declaration of Human Rights, but more importantly, according to the Declaration of Commitment on HIV/AIDS.

This study focused on the first response to the HIV/AIDS disease, namely, prevention, instead of the second, treatment and care. As such, the socio-economic factors which contribute to the vulnerability of refugee women to infection were studied. These are: the breakdown of social systems leading to risky sexual behaviour, sexual violence, the armed forces as carriers of the virus, inadequate camp structure and insufficient access to resources and opportunities. These socio-economic factors of vulnerability are problem areas which leave refugee women vulnerable to infection, and yet, these are weak but surmountable points, which, should they be responded to adequately, have the potential to mitigate the threat to refugee women's human security. Analysis of the responses of Kenya and Tanzania reveal that these African states have not sufficiently made use of this opportunity to assuage the threats faced by refugee women.

Host states are failing refugee women in numerous ways. These include a lack of increased protection to accompany the increase in power resulting from a breakdown in social systems and agents of host states actually perpetrating sexual and gender-based violence against refugees instead of protecting them from this. Also, inadequate camp structures and poorly trained armed forces lacking gender sensitivity or HIV/AIDS specific training, and finally, because host states do not provide sufficient access to resources and opportunities.

This is revealed by their inadequate levels of compliance to the relevant instruments of international law, in particular the Declaration of Commitment on HIV/AIDS. While it is acknowledged that there are various constraints on state compliance, it is unquestionable that in failing to mitigate these factors of vulnerability, the host state is playing a dominant role, over and above other relevant actors within the international refugee regime, such as UNHCR, in the protection of refugee women. This is unfortunately a negative role as it acts in accordance with realist theory in pursuit of its own interests. Also, the dominance of the state over and above the international refugee regime as a whole reveals the failures of regimes in practice. Regime theory espouses sets of principles, rules, norms and decision-making procedures which while not always guaranteeing compliance, inform the actions taken by states. Evidently, the incentives for compliance within the ambit of the international HIV/AIDS and refugee regimes do not sufficiently influence the domestic structures and processes of the host states, thereby revealing the failure of regime theory in this case. The pervasive nature of the HIV/AIDS pandemic coupled with the untenable existence of refugee women in protracted states of displacement demands that recommendations to the host states, UNHCR, and the international community, be presented.

6.2. RECOMMENDATIONS

The complexities of HIV epidemics in refugee communities within host states create a wide range of opportunities on which to focus resources, ranging from small-scale interventions to large scale policy changes. The challenge is to develop and select programmes that will have the largest impact for this marginalized group while efficiently utilizing scarce resources.

To the governments of Kenya and Tanzania:

First and foremost, compliance with international laws such as 1951 Convention relating to the Status of Refugees and its 1967 Protocol as well as international customary law, including such principles as *non-refoulement*, is mandatory. While it is acknowledged that serious strain is placed on these countries by providing refugees with asylum, in the absence of durable solutions, the discussion of which is beyond the remit of this paper, the Somali and Burundian refugees who have lived for extended periods of time within these borders, deserve the same enjoyment of rights as do foreign nationals. This will have the ripple effect of alleviating the numerous human rights abuses faced by them on a daily basis such as harassment by authorities, gender-based and sexual violence and inequitable access to opportunities.

Secondly, given the sizeable numbers of refugees in both of these states, the epidemics in refugee camps needs to be incorporated into their HIV National Strategic Plans. As discussed, both states are characterized by a generalized epidemic, but the neglect of a significant portion of the population, indigenous or not, is absurd. So as to lessen the threats posed by the factors of vulnerability, refugees should be afforded with the same education and information initiatives which have successfully brought down prevalence levels amongst the local populations. This can only but benefit the local populations of these host states as it eliminates one more group, refugees, from being MARPs. Continuing the thread of decreasing marginalization of refugee women, all HIV/AIDS programmes should address the disproportionate disease burden carried by women, and act responsively in accordance with the Declaration. Effective approaches include sensitisation, training and behaviour change communication programmes targeting men and boys as well as women and girls.

Fulfilment of those two recommendations will consequently lessen the amount of effort and resources required by host states in decreasing the risk of infection held by the factors of vulnerability discussed in this study. Factor specific recommendations require less intervention by the host state but are nonetheless significant.

- With regard to the breakdown of social systems and the resultant shifting in power balances as well as changes in sexual behaviour, host states need to afford refugee women more protection in the form of recourse to the law. Outreach programmes to break the stigma and resultant discrimination of HIV would also be beneficial within communities lacking in traditional support structures to decrease the discrimination surrounding the disease.
- Armed forces need continued gender and HIV training so as to keep prevalence levels down and respect for human rights of women up but more importantly, appropriate mechanisms of enforcement grounded in human rights must be established together with punitive measures for personnel found to perpetrating sexual violence against refugees or engaging in transactional sex with refugee women. Education interventions within the police force and army would be useful as well as programmes to improve STI/HIV awareness and treatment within the regular military.
- Despite the fear of permanence, more land needs to be availed within the refugee camps, especially in Kenya. This will significantly improve Camp conditions. Increased lighting and trained border patrols will also decrease the vulnerability of refugee women.
- HIV/AIDS programs need to be directed at refugee men and women focusing on risky sexual behaviour and social norms that increase the risk of infection as well as compliance with legislation which denounces sexual abuse. In addition, support programmes for sex workers and refugee women who have suffered from SGBV must be created to address the specific determinants of their vulnerability to HIV/AIDS and SGBV, followed by educational and vocational programmes to improve the economic empowerment of refugee women forced into transactional sex.
- As mentioned, mitigating the threat found in the lack of access to resources and opportunities will only be possible once host states afford refugees the same full complement of rights enjoyed by foreign nationals as it is this fundamental marginalization of refugee women, in defiance of international obligations and commitments, that acts as the greatest contributor to their vulnerability to HIV/AIDS.

To UNHCR and the international community:

- Publicly denounce the exclusion of refugees from HIV National Strategic Plans as well as non-compliance by host states with their international commitments.
- Improve the vigour with which the Declaration is monitored, with the long-term goal of not merely recommending the responses of states but providing legislation-based policy obligations for states.
- Introduce a new protection monitoring system in the camps focusing on the abuses such as those presented in this report; especially SGBV, and advocating on behalf of the victims to prevent further abuses.
- Advocate the provision of health services and counselling for victims of SGBV as well as sex workers so as to break the cycle of transactional sex.
- Create funding mechanisms that simplify and accelerate funding processes to increase interest and efficiency and in doing so provide an incentive for host states to comply with their international obligations. These could possibly include bolstering civil society and NGOs so as to assist the host state in terms of infrastructure.
- Ensure that internationally funded HIV/AIDS programmes include refugees where there is a significant number so as to achieve comprehensive interventions as well as review the monitoring mechanisms used to assess the implementation of these programmes.
- Encourage the resolution of exactly who is responsible for the reproductive health of refugee women in protracted states of displacement: development agencies or HIV/AIDS specialists, the international refugee community or the host states as evidently, refugee women in protracted states of displacement are falling within this gap.

The deadly pervasiveness of the HIV/AIDS pandemic coupled with the untenable marginalization of women refugees in protracted states of displacement is clearly a weak point for the international community. Host states are instructing the turn their lives take by failing to protect them from the threat to their human security posed by HIV/AIDS. As such, this is a problem falling within the ambit of HIV/AIDS, human rights, forced migration, essentially a problem which resonates across the

international community. Therefore, the international community, and the host states have a responsibility to review the current realities of this forgotten majority and the roles they play within their existence. In this way, the dominance held by the host states might be lessened, as evidently, adequate protection from the HIV/AIDS threat to refugee women's human security is not being provided.

REFERENCE LIST

“Addressing the Needs of Women Affected by Armed Conflict”, *An ICRC Guidance Document*, March 2004, http://www.unicef.org/emerg/files/ICRC_women_war.pdf, Accessed 26 January 2010

“Addressing HIV-Related Stigma and Resulting Discrimination in Africa: A Three-Country Study in Ethiopia, Tanzania, and Zambia”, *Information Bulletin*, ICRW March 2002

“African Charter on Human and People’s Rights”, adopted June 27, 1981, <http://www.umn.edu/humanrts/instree/z1afchar.htm>, Accessed 13 November 2010

Ayiera, E., “Bold advocacy finally strengthens refugee protection in Kenya”, *Forced Migration Review*, 28, www.fmreview.org/FMRpdfs/FMR28/14.pdf, Accessed 24 November 2010

Banerjee, S. And Sharma, U., “Gender, Sexuality, Rights and HIV: An Overview for Community Sector Organizations”, *International Council of AIDS Service Organizations*, 2007, <http://www.icaso.org/publications/genderEN1.pdf>, Accessed 21 October 2010

Barnett, T. and Whiteside, A., *AIDS in the Twenty- First Century*, Palgrave MacMillan, New York, 2002

Bennett, A. and George, A.L., *Case Studies and Theory Development in the Social Sciences*, The MIT Press, Cambridge, Mass, 2005

Brown, G. K., “Gender Roles in Refugee Camps: The Lasting Impact of Refugee Interventions in Tanzania”, May 2006, <http://fletcher.tufts.edu/research/2006/Brown.pdf>, Accessed 22 November 2010

Callamard, A., “Refugee Women: a gendered and political analysis of the refugee experience” in Ager, A., (ed.): *Refugees*, Pinter, London, 1999

Carballo, M. et. al., “Post-conflict transition and HIV “, *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010

Chege, A., “Interventions linking gender relations and violence with reproductive health and HIV: rationale, effectiveness and gaps”, *Population Council's FRONTIERS Agenda Special Focus*, 2005, http://www.popcouncil.org/pdfs/frontiers/journals/Agenda_Chege05.pdf, Accessed 24 October 2010

Cuellar, M., “Refugee security and the organizational logic of legal mandates”, *Georgetown Journal of International Law*, 37 (4), Summer 2006

Convention Relating to the Status of Refugees”, Adopted on 28 July 1951, <http://www2.ohchr.org/english/law/pdf/refugees.pdf>, Accessed 6 October 2010

Chen, G., “Unseen, Unheard, Unaided: Urban Refugees in Dar es Salaam, Tanzania”, <http://www.refugees.org/article.aspx?id=1173>, Accessed 8 October 2010

Cross, S., "Refugees and Legal Rules: Can the International Refugee Regime Provide adequate Protection?", http://www.allacademic.com//meta/p_mla_apa_research/citation/1/8/0/7/5/pages180752/p180752-28.php, Accessed 17 May 2010

"Database and Legislation", <http://www.unesco.org/shs/ethics/geo/user/?action=Geo4View&db=GEO4&id=1&type=TREATY&lng=en&criteria=Tjs%3D>, 12 January 2011

"Declaration of Commitment on HIV/AIDS: five years later", Report of the Secretary-General, *UNGASS Sixtieth Session*, 24 March 2006

Delargy, P., and Klot, J., "Sexual violence and HIV/AIDS transmission", *Forced Migration Review: Sexual Violence*, Issue 27, January 2007, <http://www.fmreview.org/FMRpdfs/FMR27/full.pdf>, Accessed 16 January 2010

De Waal, A., et. al."HIV/AIDS, security and conflict: new realities, new responses", *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010, <http://www.fmreview.org/Aids.pdf>, Accessed 31 January 2010

Egeland, J., "International Responsibilities", *Forced Migration Review: Sexual Violence*, Issue 27, January 2007, <http://www.fmreview.org/FMRpdfs/FMR27/full.pdf>, Accessed 16 January 2010

Finnemore, M., and Sikkink, K., "*International Norm Dynamics and Political Change*", *International Organization*, 52, 4, Autumn, 1998

"From Horror to Hopelessness: Kenya's Forgotten Somali Refugee Crisis", *Human Rights Watch*, March 2009, <http://www.hrw.org/en/reports/2009/03/29/horror-hopelessness>, Accessed 17 May 2010

"Gender, Sexuality and Violence in the context of HIV and AIDS", ICRW, <http://www.icrw.org/files/publications/Gender-Sexuality-and-Violence-in-the-context-of-HIV-and-AIDS-a-Call-to-Action.pdf>, Accessed 13 January 2010

Goodwin-Gill, G., "Convention Relating to the Status of Refugees and Protocol Relating to the Status of Refugees", <http://www.untreaty.un.org/cod/avl/ha/prsr/prsrs.html>, Accessed 17 May 2010

"Guidelines for Gender-based Violence Interventions in Humanitarian Settings", *The IASC*, September 2005, <http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402>, Accessed 21 January 2011

Gubin, S.L., "Between Regimes and Realism – Transnational Agenda Setting: Soviet Compliance with CSCE Human Rights Norms", *Human Rights Quarterly*, Vol.17, No.2, May 1995

Gupta, G.R., "Gender, Sexuality and HIV/AIDS: The What, the Why and the How", Plenary Address XIIIth AIDS Conference Durban, South Africa, 12 July 2000, <http://www.genderandaids.org/modules.php?name=News&file=articles&sid=36>, Accessed 24 October 2010

Hanson, B., et. al., "Refocusing and prioritizing HIV programmes in conflict and post-conflict

settings: funding recommendations”, *AIDS*, 2008, Vol 22.

“Health Sector HIV and AIDS National Strategic Plan (HSHSP) 008-2012”, The United Republic of Tanzania Ministry of Health and Social Welfare,
http://hdptz.esealtd.com/fileadmin/documents/Key_Sector_Documents/HIVAIDS_Documents/HIV_AIDS_Sector_Strategic_Plan_June_07.pdf. Accessed 21 January 2011

“HIV/AIDS and Gender: Fact Sheet Overview”, *UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS*, http://www.unfpa.org/hiv/docs/factsheet_genderwork.pdf, Accessed 23 October 2010

“International Covenant on Economic, Social and Cultural Rights”, Adopted on 16 December 1966, <http://www2.ohchr.org/english/law/cescr.htm>, Accessed 13 October 2011

“International Guidelines on HIV and Human Rights, 2006, Consolidated Version, *Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS*, 2006,
www.ohchr.org/english/issues/hiv/guidelines.htm, Accessed 17 May 2010

Iqbal, Z. And Zorn, C., “Violent Conflict and the Spread of HIV/AIDS in Africa”, *The Journal of Politics*, Vol. 72, No. 1, January 2010

Kagwanja, P.M., “Ethnicity, gender and violence in Kenya”, *Forced Migration Review: Gender and Displacement*, Issue 9, December 2000,
<http://www.fmreview.org/FMRpdfs/FMR09/fmr9full.pdf>, Accessed 16 June 2010

“Kenya National AIDS Strategic Plan 2009/10 – 2012/13”, National AIDS Control Council, November 2009, http://www.ilo.int/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127531.pdf, Accessed 21 January 2011

“Kenya: Relieve Somali Refugee Crisis”, Human Rights Watch, 5 June 2009,
<http://www.hrw.org/en/news/2009/06/05/kenya-relieve-somali-refugee-crisis>, Accessed 13 October 2010

Krasner, D., “Structural Causes and Regime causes: Regimes as Intervening Variables” in Krasner, S. (ed.), *International Regimes*, Cornell University Press, Ithaca, 1983

Lindley, A., “Crisis and Displacement in Somalia”, *Forced Migration Review: Protracted Displacement*, Issue 33, September 2009

“List of Countries which have signed, ratified/acceded to the African Charter on Human and People’s Rights”, <http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf>, Accessed 12 January 2010

Loescher, G. et al, “Protracted Refugee Situations and Peacebuilding”, *United Nations University*, No.1, 2007, <http://www.un.edu/publications/briefs/policy-briefs/2007/PB01-07.pdf>, Accessed 16 March 2010

Loescher, G. and Milner. J., “Responding to Forced Migration in a ‘Reforming’ UN System: The case of Burundian refugees in Tanzania”, *Forced Migration Policy Briefing* 6, Refugees Studies Centre, January 2011, <http://repository.forcedmigration.org/pdf/?pid=fmo:5937>, Accessed 19

January 2011

Lubbers, R., "UNHCR Reaffirms Commitments to HIV/AIDS", UNHCR News Story, 1 December 2003a, <http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=search>, Accessed 30 January 2010

Martin, S.F., *Refugee Women*, Women and World Development Series, Zed Books, London, 1991

McGinn, T., et. al., "Forced Migration and Transmission of HIV and Other Sexually Transmitted Infections: Policy and Programmatic Responses", November 2001, HIVinSite, <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-08>, Accessed 26 August 2010

"Mobile Populations and HIV/AIDS in the Southern African Region", IOM-UNAIDS Reports on Mobile Populations and HIV/AIDS, *International Organization for Migration*, Geneva, 2003

"Monitoring the Declaration of Commitment on HIV/AIDS: GUIDELINES ON CONSTRUCTION OF CORE INDICATORS, UNGASS, July 2005

Mwangi, B., "Harsh life at the Daadab, Kenya Refugee Camp", http://www.wunrn.com/news/2007/01_07/01_22_07/012707_kenya2.htm, Accessed 31 January 2011

Patterson, A., *The Politics of AIDS in Africa*, Lynne Reiner Publisher, Colorado, 2006

Piot, P., "AIDS and Human Security", <http://www.africaaction.org/doc01/piot0110.htm>, Accessed 17 May 2010

"Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)", *HIV InSite Knowledge Base*, November 2011, <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-08>, Accessed 11 October 2011

Roberts, B., "HIV/AIDS, Conflict and Forced Migration", *FMO Thematic Guide: Forced Migration and Health*, July 2004, <http://www.repository.forcedmigration.org/pdf/?pid=fmo:5147>, Accessed 16 October 2010

"Routinely Targeted: Attacks on Civilians in Somalia", *Amnesty International*, 6 May 2008, *AI Index: AFR 52/006/2008*

"Refugee Services Department", Tanzania Ministry of Home Affairs, , http://www.moha.go.tz/index.php?option=com_content&view=article&id=46&Itemid=14, Accessed 31 January 2011

Seckinelgin, H., Bigirimwami, J., and Morris, J., "Gendered violence and HIV in Burundi", *Forced Migration Review: HIV/AIDS, Security and Conflict*, October 2010, <http://www.fmreview.org/Aids.pdf>, Accessed 12 January 2010

Seeley, J., Grellier, R. and Barnett, T., "Gender and HIV/AIDS impact mitigation in sub-Saharan Africa — Recognizing the constraints", *Journal of Social Aspects of HIV/AIDS*, Vol. 1, No. 2, August 2004

"Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, Guidelines for Prevention and Response", *UNHCR*, May 2003, http://www.ec.europa.eu/echo/files/policies/sectoral/health_2003_sgbv_against_refugees_returnees_idps_unhcr.pdf, Accessed 15 October 2010

- "Somali camps 'Unfit for Humans'", *BBC News*, 3 September 2009, <http://www.news.bbc.co.uk/2/hi/africa/8235089.stm>, Accessed 19 January 2010,
- Spiegel, P.B., "HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action", *Disasters*, 2004, 28(3)
- "Status of Treaties", Chapter IV: Human Rights, *United Nations Treaty Collection*, 7 January 2011, <http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>, Accessed 13 September 2011
- "Tanzania", *Women Direct*, <http://www.womendirectafrica.org/countrydetails.php?countryID=4>, 2008, Accessed 17 May 2010
- "Tanzania: In the Name of Security", *Human Rights Watch*, July 1999, Vol.11, No.4, <http://www.hrw.org/legacy/reports/1999/tanzania/>, Accessed 18 November 2010
- "The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)", Adopted in 1979, <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>, Accessed 12 October 2010
- Thomson, J., "Durable solutions for Burundian refugees in Tanzania", *Forced Migration Review: Protracted Displacement*, Issue 33, September 2009
- Torres, A. B., "FMO Thematic Guide: Gender and Forced Migration", http://www.forcedmigration.org/678_gender_3241/thematicfmo/231, Accessed 11 October 2010
- Turner, S., "Vindicating Masculinity: The Fate of Promoting Gender Equality", p.8, *Gender and Displacement*, *Forced Migration Review*, Issue 9, December 2000
- "United Republic of Tanzania: Global Needs Assessment", *UNHCR*, <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e45c736>, Accessed 17 May 2010
- "Universal Declaration of Human Rights", Adopted on December 10, 1948 <http://www.un.org/en/documents/udhr/index.shtml>, Accessed 17 October 2010
- "UN Millennium Development Goals Background", *United Nations*, <http://www.un.org/millenniumgoals/bkgd.shtml>, Accessed 13 January 2011
- Waltz, K. in Donnelly, J., *Realism and International Relations*, Cambridge University Press, Cambridge, 2000
- Ward, J., and Marsh, M., "Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources", *UNFPA Briefing Paper*, June 2006, <http://www.unfpa.org/emergencies/.../docs/finalbrusselsbriefingpaper.pdf>, Accessed 15 October 2010
- "Welcome to Kenya: Police Abuse of Somali Refugees", *Human Rights Watch*, 17 June 2010, <http://www.hrw.org/en/reports/2010/06/17/welcome-kenya-0>, Accessed 13 September

2010

“XVI. Population, Refugees and the Millennium Development Goals: A UNHCR Perspective”,
United Nations High Commissioner for Refugees,
http://www.un.org/esa/population/publications/PopAspectsMDG/15_UNHCR.pdf, Accessed
12 January 2011

Young, O.R., “Is Enforcement the Achilles’ Heel of International Regimes?”, *Governance in World Affairs*, 1999