
A Dissertation Submitted in Partial Fulfillment of the Requirement for the Award of the Degree of Master of Arts in International Studies at the Institute of Diplomacy and International Studies (IDIS), University of Nairobi.

MAY 2004
DECLARATION

This Dissertation is my original work and has not been presented for a degree in any other University.

Sign ___________________________ Date ___________________________

OCHIENG PIUS O.

This Dissertation has been submitted for examination with my approval as a University Supervisor.

Sign ___________________________ Date ___________________________

DR. JOSPHINE ODERA
DEDICATION

This grand gift from above, the dissertation, I dedicate to my family, the closest people to me.

My parents: Mr. Basil Ochieng Ogutu and Mrs. Nasta Awino Ochieng. Dad, your quiet diplomacy has prevailed against all odds to ensure that the path of my life takes the pre-ordained direction of discipline and success. You have prayerfully stood out of my way to let my life be formed. This far I have reached and I appreciate you. And you Mama, my friend and confidant, my mentor and challenger, back home I bring the intellectual sheaves.

To all my siblings: Akoth, Paul, Cerry, Judy, Caro, Gabby and Simon – my admirers and supporters – share with me the joy of this gift. It is painful although we regret not that Ben and Rick had to complete their life-journeys before this ‘visitation’.

To all of you I declare, “The Lord is our shepherd, we shall not want!”
ACKNOWLEDGMENT

I am lost for words to express my very heartfelt gratitude to multitudes of individuals and organizations whose assistance and good-will have propelled my efforts towards this grand realization and achievement. "Never before has any individual in the history of our nation owed so much to so many".

I lift up high my cap in appreciation to Dr. Josaphine Odera, my supervisor, whose commitment and analytical skills kept me on my toes to search and to reason out facts for "without investigation, there is no permission to talk". Special thanks to her for the regular attention she accorded me and for her limitless referrals to individuals and organizations. I sincerely thank her secretaries, Lucy and Runro who were never tired of receiving my calls and filing my drafts.

I hereby also acknowledge the entire staff of IDIS whose lives have productively brushed against mine. To Mr. Chesom I say great! because of the many hours he allowed me into his office and engaged me in vigorous intellectual gymnastics. Mr. Ikiara was always there to cheer up my heart, to him, the sky is always the limit. Special gratitude to Prof. Nyunya whose orientation in methodology was my launching net into this exercise. High regards to Prof. Nzomo and Dr. Mwagiru whose thoroughness did no mean transformation to my scholarly stature.

Bravo! To Ms. Nogloma who introduced me to French and made sure that I learnt it through thick and thin. Merci madamme! I praise the friendliness of Mina and Josephine, the IDIS office staff who served me with all that professionalism offers. Not forgetting Dr. Moustaffa who made sure I understood the difference between undergraduate and postgraduate studies. For the sake of his assignments I burnt the midnight oil not for a few nights. Dr. Nyinguro was not mean with his several and must-do assignment. From him I learnt the hard lesson of fulfilling appointments and completing tasks in time.
By no means was my world complete only within the "Ivory Tower". Blessings to all my friends who literally 'mined' their pockets to fuel my academic engine, silver and gold they brought, prayers and supplications they made. Special ululations to Opati, Okeyo, Bwila, Oundo, Jaika, Amos, Mwangi, and to all men and women who empathized with my vision and shared in my mission. To Dr. (Mrs.) Ndeda who recommended me for the course and took all the keenness and kindness to write down every positive trait and gift in me, my heart beats with gratitude.

Special honour to Skye Hughes of IRC who gave all the information I needed. She never thought I was a bother. And to all men and women I interviewed: Kariuki Karanja (UNHCR), Dr. Chebet (NASCOP), Mr. Mambo (NACC), Ms. Maingi (AACC), Susan (Action-Aid), Ayiemba (RCK). I also acknowledge the free offer to use libraries, Resource Centres and materials by various organizations such as UNCHR, UNAIDS, WHO, Refugee Consortium of Kenya, Kenya AIDS NGOs Consortium, NASCOP, NACC, USIU, UNESCO, AACC, Action-Aid and the University of Nairobi Electronic Journals and UN Sections.

Last but not least, I will live to remember all my comrades in the M.A. Class: Maingi, Muganda, Manyange, Munynyi, Omondi, Kagosha, Kinyanjui, Kagwanja, Njeremanini, Ondieki and Ngeno. I enjoyed all the twelve clusters of idiosyncratic variables that more often than not clashed and led to near-fights. No regrets, we differed but never disintegrated. Like billiard balls, we learnt the hard way to take our rightful positions but never lost our hegemonies.

To all these I say, "You have refreshed me, may you be refreshed yourselves!"

Ochieng', Pius O

May, 2004
# Table of Contents

DECLARATION .................................................................................................................... ii  
DEDICATION .................................................................................................................... iii  
ACKNOWLEDGEMENT ................................................................................................. iv  
TABLE OF CONTENTS ....................................................................................................... vi  
ABBREVIATIONS ................................................................................................................ ix  
ABSTRACT .......................................................................................................................... xi  

## CHAPTER ONE: Background to International Organizations and HIV/AIDS among Refugees

1. Introduction ................................................................. 1  
2. Statement of the Problem ............................................... 3  
3. The Objectives of the Study ............................................... 4  
4. Justification of the Study ................................................... 4  
5. Hypotheses ........................................................................ 6  
6. Literature Review .......................................................... 6  
7. Theoretical Framework ...................................................... 16  
8. Definition of Terms .......................................................... 19  
9. Research Methodology ..................................................... 21  

## CHAPTER TWO: Historical Assessment of the Role of International Organizations in the Fight against HIV/AIDS in Sub-Saharan Africa

1. Introduction ........................................................................ 23  
2. Global Effort against HIV/AIDS .......................................... 24  
3. The Global Fund to Fight AIDS, Tuberculosis and Malaria .......... 28  
   - Policies on Antiretroviral Drugs ............................................. 29  
   - HIV/AIDS Control and Debt Relief ........................................ 31  
   - The Role of the United Nations ............................................. 34  
   - World Health Organisation .................................................. 34
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Nations Development Programme</td>
<td>35</td>
</tr>
<tr>
<td>United Nations Population Fund</td>
<td>35</td>
</tr>
<tr>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
<td>36</td>
</tr>
<tr>
<td>United Nations Children's Fund</td>
<td>36</td>
</tr>
<tr>
<td>United Nations International Drug Control Program</td>
<td>37</td>
</tr>
<tr>
<td>International Labour Organization</td>
<td>37</td>
</tr>
<tr>
<td>The World Bank</td>
<td>37</td>
</tr>
<tr>
<td>The Joint United Nations Programme on HIV/AIDS (UNAIDS)</td>
<td>38</td>
</tr>
<tr>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
<td>38</td>
</tr>
<tr>
<td>The Role of the Civil Society and Government Commitment</td>
<td>40</td>
</tr>
<tr>
<td>The Role of Faith-Based Organizations</td>
<td>43</td>
</tr>
<tr>
<td>Sub-Saharan Africa – HIV/AIDS Policies</td>
<td>45</td>
</tr>
<tr>
<td>Policies Relating to HIV/AIDS among Refugees</td>
<td>49</td>
</tr>
</tbody>
</table>

**CHAPTER THREE: The Case Study: The Role of International Rescue Committee in the Fight against HIV/AIDS among Refugee at Kakuma Refugee Camp in Kenya**

**Introduction** ...................................................... 53

- The Spread of HIV/AIDS at Kakuma Refugee Camp .......................................... 54
- HIV/AIDS at Kakuma – The Response of International Organizations ................. 57
- UNHCR and HIV/AIDS at Kakuma ........................................................................... 57
- IRC and HIV/AIDS at Kakuma .............................................................................. 60
- The Role of NCCK and JRS as Partners of IRC .................................................. 71
- Constraining Factors to IRC’s HIV/AIDS Program at Kakuma............................... 73
- The Impact of IRC HIV/AIDS Program at Kakuma ............................................... 76

**CHAPTER FOUR: The Impact of International Policies in the Fight against HIV/AIDS among Refugees in Sub-Saharan Africa** ........................................................... 78

**Introduction** .......................................................... 79

- HIV/AIDS among Refugees – Prevention, Control and Care .................................. 80
CHAPTER FIVE: Conclusions and Recommendations

Introduction ............................................................................................................... 111
HIV/AIDS mong Refugees at Kakuma .................................................................... 112
Gender and HIV/AIDS among Refugees ................................................................ 115
HIV/AIDS - An International Problem that Needs International Response ...... 116
Collaboration Against HIV/AIDS among Refugees ................................................118
Funding for HIV/AIDS Programs among Refugees..................................................122
Issues for Further Research ....................................................................................125

REFERENCES ...................................................................................................................126
**Abbreviations**

AIDS – Acquired Immuno-Deficiency Syndrome

CDC – Centre for Disease Control

FHI – Family Health International

GTZ – German Technical Co-operation

HIV – Human Immuno-Deficiency Virus

IGO – Intergovernmental Organisation

INGO – International Non-governmental Organisation

IO – International Organisation

IRC – International Rescue Committee

UN – United Nations

UNAIDS – United Nations Inter-Agency against HIV/AIDS

UNFPA – United Nations Population Fund

UNHCR – United Nations High Commissioner for Refugees

WHO – World Health Organisation
ABSTRACT

The study sets out to investigate and analyse the role that is played by international organizations in the combat against HIV/AIDS among refugees in sub-Saharan Africa. Two categories of international organizations are looked at: the intergovernmental organizations which are the lead agencies in policy formulation and funding of programs, and non-governmental organizations which are the implementing agencies. Specifically, an international non-governmental organization, International Rescue Committee – which is involved in operations against HIV/AIDS among refugees globally is the case study. The study looks at its operations at Kakuma Refugee Camp in Kenya from 1992 to the year 2002.

The study analyses; The role of states; The aspects of collaborations between IOs and states, and among IOs themselves. The policy frameworks – nationally and globally; The issue of funding of HIV/AIDS programs; The spread and impact of HIV/AIDS among refugees; And the relationship between gender and HIV/AIDS among refugees.

The study reaches a number of findings. The International Organizations are limited in their combat against HIV/AIDS among refugees due to: insufficiency of funding for such programs, poor collaboration efforts among the stakeholders, diverse socio-cultural and economic dynamics among refugee communities, the failure of the state to honor international policies, and the technical limitations in staffing and coordination of the programs. The state is also limited in terms of low political will, poor policy provision, and financial and expertise insufficiency.

The study concludes that for HIV/AIDS programs among refugees to be effective, there should be close and keen observance of universal precautions, proper establishment of relevant infrastructure, continuous training of staff (both local and refugee), continued funding without conditionalities, closer collaboration among all the stakeholders, policies by all the states and the international organizations.
The study advocates a systematic monitoring and assessment of the impact of HIV/AIDS on various sectors among refugees such as health, education, security and households. It further recommends an investigation into the appropriate ways of incorporating refugees in the National Strategic Plan of HIV/AIDS, challenges to such measures and the possible remedies against the stumbling blocks to such efforts.
CHAPTER ONE

Background to International Organizations and HIV/AIDS Among Refugees

Introduction

There are around 40 million refugees and displaced people in the world today who have been forced from their original homes by emergencies such as floods, earthquakes, drought or even war or strife (UNAIDS 2001). Most refugees live in special camps in host countries and some of them have remained displaced for years because of the prolonged conflicts.

Forced population movements often place people at greater risk to HIV transmission (Shlarkshall, 2000). HIV/AIDS is often overlooked in the immediate wake of a disaster because there seem to be more important things to do. However, it is just at this time that HIV/AIDS threatens the most (Wolfers, 2000). While HIV/AIDS does not discriminate among individuals, certain groups of people have greater risks of exposure and are thus vulnerable to infection. These risk groups include migrants and refugees, especially those uprooted by conflict (FHI, 2002). HIV can spread faster where there is poverty, powerlessness, lawlessness and social instability - conditions that often give rise to or accompany forced displacement (UNHCR, 2000: 253).

Kakuma Refugee Camp was previously believed to be a low risk area as the majority of the refugees are Sudanese who traditionally have had lower rates of infection. However, the camp health system is increasingly detecting the presence of the disease (IRC, 2001).
Of all symptomatic individuals attending IRC health facilities, approximately 30% test positive for HIV antibodies.

Appreciation and understanding of the factors that contribute to the spread of HIV in Kakuma is essential in order to develop relevant and adequate responses. There is a disproportionate demographic representation of unmarried adolescent males in the camp, many of whom live in group settings. The adolescents take sexual risks and face exploitation in the absence of traditional socio-cultural constraints (IRC, 2002).

Kakuma, like any other refugee camp is under the mandate of UNHCR, the globally singled out UN agency charged with refugee matters. So far, UNHCR has developed a policy on HIV/AIDS - UNHCR Policy on HIV/AIDS. This is in line with the requirement that all refugee operations should respect and protect human rights (UNHCR, 2000).

Several organisations are involved in the combat of HIV/AIDS in Kakuma. These are namely, International Rescue Committee, Jesuit Relief Services and the National Council of Churches of Kenya. Of the three, IRC is the leading agency charged with health issues in the camp (UNHCR, 2002).

Kakuma Refugee Camp is located in Turkana District in Kenya. It is located 127KM south of the Kenya/Sudan border and 120KM northwest of Lodwar town. It is home to about 80,028 refugees from eight different states and twenty ethnicities. 80% of the
refugee population is made up of Sudanese while Somalis comprise 15%. The rest are from Ethiopia, Uganda, Rwanda, Burundi, Democratic Republic of Congo and Eritrea (IRC, 2001)

Statement of the Problem

The problem that was investigated in the study could be summarised by the following questions:

1. What is the Role of international organizations in the fight against HIV/AIDS among refugees in Sub-Saharan Africa?

2. What is the impact of the activities of the international organizations in the fight against HIV/AIDS among refugees in Sub-Saharan Africa?

3. What are the appropriate policies strategies that International Organizations need to take to be more effective in their combat against HIV/AIDS among refugees in Sub-Saharan Africa?

Rolf Korte (1988) asserts that since there is neither an effective treatment nor vaccine against the AIDS virus, prevention must remain the most important weapon. If the measures to combat AIDS in Africa are to succeed, not only will a high level of international co-operation be required, but also a willingness by partner countries to face up to the issue.

Nyamwaya (1988) concurs with Korte and illustrates the role that has to be played by both the non-governmental and religious organisations. As rightly stressed by the World
Health Organisation, only a worldwide effort can stop AIDS. International co-operation is needed to remove biases and misconception about AIDS.

But, what is actually the role that international organizations play in response to the above suggestions, particularly among the refugees in Sub-Saharan Africa? Considering the fact that international organizations work all over the world and represent the interests and values of the international community, what is the relevance and applicability of their efforts in Africa? Do these activities have any impact at all?

**The Objectives of the Study**

This study aimed at pursuing the following objectives.

1. To critically analyse the role-played by international organizations (International Rescue Committee) in the fight against HIV/AIDS among refugees.

2. To assess the impact of international policies in the fight against HIV/AIDS among refugees in Sub-Saharan Africa

3. To recommend effective strategies to be used by international organizations in the fight against HIV/AIDS among refugees in Sub-Saharan Africa.

**Justification of the Study**

This study is justified on both policy and academic/scientific grounds.
Policy Justification

International organizations are involved in the fight against HIV/AIDS in many different parts of Sub-Saharan Africa. The international non-governmental organizations (INGOs) and the International Governmental Organisations (IGOs) are working together in this area. The findings of this study will be useful for UNHCR, in evaluating its policy on HIV/AIDS. It will be handy to the Centre of Disease Control in assessing its policies on funding HIV/AIDS project. It will be useful to IRC in evaluating their project. In general, both the donor and implementing agencies will find it necessary in evaluating the relevance, effectiveness, efficiency and impact of the intervention measures against HIV/AIDS among refugees in Sub-Saharan Africa.

Academic/Scientific Justification

A number of scholars have written on refugees, especially on the problems of refugees like protection, repatriation, or settlement (Chandler 1959: 250, Kamungi, 2000: 12, Hamrell, 1967: 77). Various studies have also been carried out on the role of international organizations among refugees (Hamrell, 1967: 70, IUEF, 1972: 69). The same applies to the topic of HIV/AIDS.

However, little incisive study has been done on the area of HIV/AIDS among refugees in Sub-Saharan Africa. In fact even less has been done on the effectiveness of the activities of IOs in the combat against HIV/AIDS among refugees. It is against this background that the study attempted to bridge the existing gaps of knowledge among the concepts of refugees, HIV/AIDS and international organizations. By so doing, the research has
availed information and data on the activities of IOs among refugees in the combat against HIV/AIDS. It has also tried to boost the literature in this area of study. It should act as a catalyst to scholars of international studies to venture into further research. It has attempted to fill the gaps in the literature and add to the theory on international organizations.

**Hypotheses**

1. The increase of the activities of international organizations reduces the spread of HIV/AIDS among refugees.

2. The intervention programmes of international organizations in the combat against HIV/AIDS among refugees are significant but not sufficient.

3. The intervention of the state in the fight against HIV/AIDS among refugees is necessary but limited.

**Literature Review**

The problem of HIV/AIDS among refugees is not unique to sub-Saharan Africa, though it was home to about 70% of the people who became infected with HIV in 1998 (UNAIDS, 2001: 5). There is need to narrow down to a small geographical region to scrutinize the peculiar activities of international organisations against HIV/AIDS among refugees in a particular case study. The proposed study will look at the Kakuma refugee camp in Kenya and but will also draw examples from other parts of sub-Saharan Africa such as Tanzania, Botswana, Sierra Leone, Rwanda, Burundi and the Democratic Republic of Congo which are also inhabited by large refugee populations and therefore have similar
political, social and economic dimensions occasioned by the spread and impact of HIV/AIDS on the refugees.

The literature reviewed here will be divided into three parts, because the proposed study has looked at three variables. The first part looks at studies on refugees, which is the independent variable: the causes of their flows, their problems, and the traditional responses by the international community. This also includes the refugee rights and other provisions within the context of international organizations' policies.

The second part is dedicated to studies on HIV/AIDS: the factors that promote its spread and the suggested preventive measures against its spread. The third part looks at the international organizations. Particular analysis will be done on what they are, their roles and functions, how they co-ordinate in the implementation of their programmes, and their shortcomings and challenges.

Refugees-A Survey of the Literature

Holborn (1975) has written extensively on refugees. She notes that in Africa, civil wars, power struggles and inter-ethnic rivalries, among others have caused refugee flows. She also traced the international efforts on behalf of the refugees from the League of Nations to responses by the international community to the problem through the 1951 UN Convention stipulations of protection and resettlement as permanent solutions. This work is useful for those looking at the refugee factor as a problem facing the international
community but does not look at the problems facing the refugees as a community, a
factor that is core in the envisaged study.

Amate (1986: 459-475) concurs with Holborn on the causes of refugees in Africa. He
gives an overview of the refugee situation in various countries and an account of the
formulation of the 1969 OAU Convention on Refugees in Africa. He describes the
conflict circumstances in different countries which cause refugee flows but fails to
discuss the conflict tragedies that face the victims during and after the conflict, and after
settling in other countries.

Kibreab (1982) illustrates that there is a large number of refugees in Africa and goes
ahead to discuss some of the causes. He points out that the refugee problems affect the
refugee himself, the country of asylum, the country of origin and the international
community. He also links the refugee problem to issues of development, as resources
have to be diverted from economic growth programmes to humanitarian work. He sees
refugees to spread tensions in a region for economic and social reasons.

Atle Grahl-Madsen (1982 65-88) has discussed legal issues concerning refugee
protection, rights and problems as has Goodwin-Gill (1983: 127-140) but they have not
shown how these protective provisions and rights can be implemented among refugees in
camps, who may not even know of such provisions. The study looked at what the
international organizations are doing to prevent the spread of HIV/AIDS among refugees,
given that there is a lot of factors in the refugee camps that expose refugees to HIV/AIDS

Macharia (1998) has addressed the inadequacies of refugee protection as provided in the 1951 UN and 1969 OAU Refugee Conventions but she has not shown how breaches of protection policies like forced repatriation and resettlement may exacerbate the spread of HIV/AIDS.

Symser (1987: 35) is among the critics against the settlement of refugees in camps, saying that they are exposed to more dangers, one of which is the risk of contracting the HIV-virus. However, it is by no means certain that self-settled refugees are generally safer or better placed than those in camps. Depending on circumstances, refugees living outside camps can be subject to a range of security and economic problems ranging from threats by resentful local people to attacks by rebel groups and forced recruitment into those groups (UNHCR, 2000). And given that the spread of HIV/AIDS is even more rampant outside the camps, they are not even safer.

UNHCR (2000) asserts that though diseases such as cholera can spread easily in hastily constructed and overcrowded camps, in many cases – particularly after the initial emergency phase – refugees in camps receive significantly better health care and other services. However, UNHCR does not explain whether these services are effective or not. The study investigated whether the activities of the humanitarian organisations aimed at fighting HIV/AIDS among refugees are bearing positive results.
UNHCR describes the challenge for the host states, humanitarian organisations and policy makers as that of ensuring that refugees are able to enjoy safe, secure and dignified conditions of life, whether they live in camps or not. But it does not show what these entities are actually doing to ensure the attainment of this goal.

According to (Ball 1996), global government spending on humanitarian assistance has increased steadily in volume over the last fifty years. The proportion of official development assistance (ODA) allocated by governments to humanitarian assistance, as opposed to long-term development also grew significantly in the early 1990s. At its height, in 1994 it represented 10% of the total ODA. What is missing in this description is the approximate value of the total ODA that is committed to HIV/AIDS projects among the refugees. It was the aim of the study to establish the amount and value of resources that donors have given towards the alleviation of HIV/AIDS among refugees in sub-Saharan Africa, and particularly at Kakuma Refugee camp in Kenya.

In the wake of international interest, it is expected that every state should ensure the safety and the security of her citizens so that their rights are not violated (UNHCR, 2000). However a country like Somalia does not have a government with firm control over its territory and its people. Who is responsible in such a case for the safeguarding of the human rights
UNHCR (2000) and Nobel (1987) recommend the linkage of relief and development. According to Nobel, the main issue here is the need to promote greater self-sufficiency for refugees in countries of asylum. The gap in this literature concerns the question whether HIV/AIDS is a relief or development problem and the kind of organisations (relief or development) which should handle it.

According to UNHCR (2000), refugee children are among the most disadvantaged victims of conflict as some of them are separated from their families, others are orphaned whereas others have to take care of their siblings and sickling parents. This denies them the opportunity to grow normally as other children and to enjoy education facilities.

HIV/AIDS-A Survey of the Literature

According to the State of World Population (UNFPA, 2002: 43) report, twenty years after the first clinical evidence of AIDS, it has become the most devastating disease ever faced by humanity, striking, on average, 14,000 men, women and children daily, the leading cause of death in sub-Saharan Africa and the world's fourth biggest killer. More than 60 million people have been infected with HIV, and AIDS has killed more than 20 million people, according to UNAIDS and WHO (2002). In sub-Saharan Africa alone, 3.5 million were newly infected in 2001. This description does not, however, narrow down to the sub-communities to which refugees belong, given the trend of the spread and the impact. The task here was to establish the level of infection among refugees in sub-Saharan Africa, particularly Kakuma refugee camp in Kenya.
Loewenson and Whiteside (2001: 23) describe the spread of the pandemic among different age groups and assert that the main reason for infection is the lack of information and prevention services. However, they do not prove whether information and knowledge of preventive measures alone are able to combat the spread. They do not consider other intervening factors such as socio-cultural and economic conditions like those existing among refugees.

According to Rau and Collins (2000: 2), economic and social changes have created an enabling environment that places tens of millions of people at risk of HIV infection. Therefore, according to them, initiatives that only seek to change behaviour are insufficient to stem the epidemic. Determinants of the epidemic go far beyond individual volition. The pandemic cannot be stopped by treating it only as a disease. HIV/AIDS accompanies poverty and is spread by poverty and produces poverty in its turn. But how the pandemic can be tackled is not addressed by the two. The measures that can be taken by the international organisations working among the refugees to combat the infection was one of the aims of this study.

However, the situation is made more complex by Epstein's (2000) illustration of "Poverty's Companions" which he considers to be the factors that have to be addressed at the same time with HIV/AIDS pandemic. One of these factors is an inadequate leadership response to either HIV/AIDS or the problem. Epstein does not operationalize what he means by "leadership"—whether it is the government, the affected community or
The international organisation system. This research investigated the relevance of the policies international organizations are applying in attempt to combat the pandemic.

The United Nations General Assembly (2000) predicted that by 2010 sub-Saharan Africa will have 71 million fewer people than it would have had without AIDS. The result is to threaten the economies, social structures and political stability of entire societies. But what is the UN doing about it? The investigation analyzed the UNAIDS and UNHCR policies on HIV/AIDS and their applicability in sub-Saharan Africa and how they have been applied at Kakuma Refugee Camp.

International Organizations-A Survey of the Literature
The task looked at international organizations, both the intergovernmental and the non-governmental. This is because of the complex nature of the refugee factor which has drawn the attention of the entire international community. Even more complex is the HIV/AIDS pandemic, especially among the refugees. So far, it is established that the intergovernmental organizations play the role of policy formulators, and donors, whereas the non-governmental play the role of donor-agencies and programme implementers.

But what are international organizations? An IO represents a form of institution which refers to a formal system of rules and objectives, a rationalized administrative instrument (Selznick 1975 9) and has a technical and material organization: constitutions, local chapters, physical equipment, machines, emblems, letterhead, stationery, a staff, and an administrative hierarchy (Duverger 1972 68)
The research was concerned not so much with the broader notions of IOs and international institutions but the more concrete manifestations of regularized international relations as seen in international organizations with their formal and material existence, separate from, though for the most part dependent on, states and groups within states (Archer 1983: 92).

There is a difference between an intergovernmental organization (IGO) and an international nongovernmental organization (INGO). An IGO derives its mandates from a coalition of states and governments. Its policies, objectives and activities are motivated by the social, economic and political interests that have pulled the states and governments into a co-operation.

It is the forming states and governments that fund a particular IGO. However, it is notable that in its day-to-day operations an IGO works as an independent entity through the coordination of its secretariat. On the other hand, an INGO is formed by private individuals and groups who are not representing the interest of any state or government. Such entities can be religious organizations or social, economic or political resource group. An INGO sources its funds from diverse sources, including even governments that are interested in what they are doing. The policies, objectives and activities clearly represent the interests of the ‘owners’.
According to the United Nations Economic and Social Council, every IO which is not created by means of intergovernmental agreements shall be considered a non-governmental organization (Economic and Social Council Resolution: 1950).

According to Archer (1983: 130), IOs have three major roles, namely: instruments, arena and actor. The role of an IO is that of an instrument being used by its members for particular ends. This is the case with IGOs where the members are sovereign states with power to limit independent action by IOs (Gunnar Myrdal 1955: 4-5) and McComick and Kihl (1979: 502). What is missing in the above description of IOs is whether they are effective in playing their roles. It will be investigated whether their policies, funding trends and their implementation strategies have any co-relationship with the levels of the spread of HIV/AIDS among refugees.

The IOs also act as arena or forums within which action takes place. The organizations provide meeting places for members to come together to discuss, argue, co-operate or disagree (Stanley Hoffman 1970: 398-9). What is not clear is whether individuals, pressure (interest) groups, or community-based organisations also have access to this arena. The refugees are a stateless people who need representation. This research attempted to verify the relationship between the International Rescue Committee and United Nations High Commissioner for Refugees in their strive to alleviate the HIV/AIDS pandemic among refugees in Kakuma.
As an actor, the international organization is independent in the international system (Wolfers 1967: 22). Whether this means that the International Rescue Committee cannot, should not or does not co-work with other organizations was the task of the study to establish and if possible recommend a redemptive measures that will strengthen the fight against HIV/AIDS among refugees at Kakuma.

Archer (1983: 31) asserts that IOs do not exist in a political vacuum. They are part of the modern state system and their institutional forms and activities reflect the hopes and fears of the governments of states within that system. He explains that a world in which mankind decides to confront universal problems such as overpopulation, pollution and destruction of the environment and starvation by the use of effective IOs will see a shift in the balance of political activity from the sovereign state to a number of strengthened global function (but also highly political) institutions.

However, he has not given an empirical evidence of any state where the activities of IOs have contradicted those of the government. The research sought to establish the relationship between the Kenyan government and its policies on HIV/AIDS and UNHCR and IRC and their policies and activities against HIV/AIDS among refugees at Kakuma.

**Theoretical Framework**

According to Hoffman, a theory is a systematic study of observable phenomena that tries to discover the principle variables to explain behaviour and reveal characteristic types of relations among national units (Hoffman, 1996: 18-42). Couloumbis and Wolfe concur
with this and add that theory helps us explain phenomena and make predictions, and in research, to organize knowledge, formulate priorities and select methods of carrying out research (1987: 16).

According to Vaubel and Willet (1995: 83), the international institutionalist approach argues that the solutions to the problems of interstate war as well as non-military disagreements can be found in diminishing the importance of the nation-states in international politics and recognizing and supporting the role of international organisations.

The theorists of this school believe that peoples and states have common interests and values that are often served better by regional or global organisations than by national structures (1995:83). They also claim that although not likely to replace nation-states altogether, IOs do foster interdependence and exchange and diffuse nationalism and autarchy. By so doing, they serve to weave together the fortunes of peoples and nations and to diminish their proclivities for war.

The international institutions approach traces much of what is wrong in international society to the particular features of the nation-state system and sees improvement only when that system is supplemented by regional or global institutions.

The principles of the international institutionalists were applied in the study by critically analysing the role of IOs in the fight against HIV/AIDS among refugees. The international
policies, the funding trends, the project designs and the quality and quantity of the experts were assessed against the levels and trends of the spread of HIV/AIDS among refugees.

IRC is an International Non-governmental Organization with operations the world over. In Africa alone, it operates in over seventeen countries such as Kenya, Tanzania, Rwanda, Botswana, South Africa and the Democratic Republic of Congo. Its headquarters are in USA but each country program is co-coordinated from the country office by a country director. There are also nine regional offices and directors to whom the country ones report to.

As already stated in the introduction, IRC works in collaboration with UNHCR, JRS, CDC and other international organizations. UNHCR which is a major IGO provides a policy framework for operation, funds projects and also overseas the running of the programs within the refugee’s settings. CDC is also another IGO that is involved in research and funding of health programs. It is a major donor to IRC at Kakuma Refugee Camp. JRS, an INGO collaborates with IRC in the fight against HIV/AIDS.

These factors of international organizations were also be compared and contrasted with those of the nation-state so as to highlight the weaknesses and strengths of each category. Therefore, this means that attention was paid to the activities of the various actors and the difficulties they have faced.
In contrast to the international institutions approach, realism views IOs as largely irrelevant to the central problem of international life, namely, the perpetual threat of devastating interstate war. To realists, the state is the sole actor and the main interests are power and sovereignty (Morgenthau, 1986 2-19).

With the nation-state very much at the centre of power in all dimensions of international life, IOs are effective only to the extent that they serve the interests of the most powerful states (Vauber and Willat, 1995 84). Therefore, one should not expect IOs to be faithful servants of the public good or the public interests, nor are they likely to facilitate significant cooperation among states (Vauber and Willat, 1995).

That notwithstanding, the research applied the principles of the international institutions approach, for it is clearly manifest that IOs are playing an important role in the fight against HIV/AIDS among refugees. They are policy makers, financiers and implementers of the intervention programmes. The pressing question was whether their efforts are effective or not. That was the motivating goal of the research.

**Definition of Terms**

**AIDS**
Acquired Immuno-Deficiency Syndrome

**HIV**
Human Immuno-Deficiency Virus
Inter-governmental Organizations
Organizations that cut across national boundaries, are composed of states and the individuals who are sent as representatives to their forums to represent the interests and policies of their own states.

International Non-governmental Organizations
Organizations that cut across national boundaries and are made up of individuals or national groups who are not official representatives of national governments.

International Organizations
A form of institutions which refer to a formal system of rules and objectives, a rationalized administrative instrument and has a formal technical and material organization: constitutions, local chapters, physical equipment, machines, emblems, letterheads, stationery, staff and an administrative hierarchy.

Pandemic
A disease prevalent over the whole of a country or over the world.

Refugee
An involuntary migrant who has been forced out of his state of residence because of persecution or threat of persecution because of his/her ethnic, religious, political or ideological affiliation. He/she is uprooted, homeless and lacks national protection and status.
Research Methodology

The study utilized both primary and secondary sources of data.

Secondary Data

This basically involved library research on published materials like books, journals, periodicals, documents, magazines, public documents, seminar papers, encyclopedias and other writings deemed relevant to this study. Visits to various NGOs, libraries, research institutions and archives within Nairobi was made.

Primary Data

Interviews was conducted with people dealing with refugees such as IRC, National AIDS Control, Jesuit Refugee Services, National Council of Churches, Kenya Consortium of AIDS NGOs, Refugee Consortium of Kenya, All African Conference of Churches, ActionAid Kenya, Ministry of Home Affairs and UNHCR personnel, NGO representatives, and other stakeholders such as National AIDS Control Programme, WHO, UNAIDS and individual refugees.

However the research did not utilize the assistance of research assistance because of the technicalities of funding such an undertaking.

Setbacks/Limitations Experienced

During the research, several setbacks were experienced: There was a limitation on the area of finance since the candidate was self-sponsored and did not secure any money for the
It was also a challenge to get information from international organizations due to their policy of confidentiality. However, the research supervisor used her personal contacts in those organizations and elsewhere to secure documents, appointments for interviews and referrals to more relevant sources.

It was also difficult to get updated material in academic libraries but resource and documentation centers at the IO offices came in handy.
Chapter Two

Historical Assessment of the Role of International Organizations in the Fight against HIV/AIDS in Sub-Saharan Africa

Introduction

Chapter one of this study has illustrated the background of the study, the problem that is being investigated, the objectives, the hypotheses and the methodology to be followed. This second chapter offers a historical overview of the role that has been and is being played by the international organizations in the fight against HIV/AIDS in Sub-Saharan Africa.

However, it is notable that some of the policy arrangements that have been looked at are global in nature. Therefore, they not only apply to Sub-Saharan Africa, but also to other parts of the world, especially the developing countries.

In this chapter, several policy issues have emerged. The international organizations have so far developed policies addressing areas such as:

- Research and development of AIDS vaccines,
- Funding of AIDS related projects,
- Prevention, care and treatment of HIV/AIDS victims,
- Capacity development of countries and organizations to strengthen the combat against HIV/AIDS,
- International co-operation, both regionally and globally against the pandemic,
The chapter has also illustrated the involvement of various international stakeholders. The United Nations system has emerged as a leading entity in the fight against HIV/AIDS. Other bodies such as religious organizations, the business sector and international non-governmental organizations have also featured as important partners in this fight.

The last section of the chapter has narrowed down from the general to a more specific area of involvement, that is, the policies that are geared towards the fight against HIV/AIDS among refugees.

**Global Effort against HIV/AIDS**

The international efforts that have been forged to combat the HIV/AIDS pandemic are built on the principles of the international institutionalists approach – a theoretical framework which views the nation-state to be too limited to handle global issues and concerns such as HIV/AIDS. The nation-state is limited in human capacity, material and financial resources, political and moral will, and technical efficacy and efficiency in solving global problems (Vaubal and Willet, 1995: 83).

On the other hand, international institutions – IOs such as IGOs and INGOs foster great global interdependence thereby enabling the collection of resources from the international community. The IOs are much more able to receive funds, technical expertise and moral
support compared to the states. Their other peculiar advantage is the general global acceptance since they don't serve any particular political interest. They serve beyond political boundaries and are basically concerned with meeting the needs that are beyond the capabilities of the state.

In this particular study, HIV/AIDS is such a great global problem that only a globally concerted effort can tackle it. It is with this understanding that the United Nations System, the civil society, the business sector and the faith-based organizations have responded in particular ways and with particular strategies.

However, it is also evidenced in the study that the international institutionalists do not disregard the role of the state totally. The state plays the role of hosting the IOs and creating for them the favorable environment for operation. The IOs also depend on the states for the implementation of some of their policies. Therefore, although the IOs are considered as the major players in the combat against HIV/AIDS, the study also found out that they play complementary roles with the state.

Within the global scene, World Health Organization held the first international meeting on AIDS in Geneva in 1983. Due to the dramatic evolution of the pandemic, WHO drew up "Global Strategy for the Prevention and Control of AIDS" and proposed a special programme to administer that plan (UNPI, 1994:51). Both were adopted by World Health Assembly in May 1987. In October 1987, the UN General Assembly addressed the AIDS pandemic for the first time, adopting Resolution 42/8, endorsing the strategy.
In 1988, the WHO Executive Board renamed the Special Programme on AIDS as the Global Programme on AIDS (GPA). The main objectives of the Global Strategy are to:

- Prevent HIV infections;
- Reduce the personal and social impact of HIV infection; and
- Mobilize and unify national and international efforts against AIDS.

Action to prevent the disease includes disseminating information about AIDS, including the promotion of safer sex practices and the use of condoms; providing health and social services, especially to detect and treat other STDs; and promoting a supportive environment – absence of poverty and discrimination (1994: 52).

Greater knowledge about the disease led to an update of the Global Strategy in May 1992, placing increased emphasis on:

- Health care for AIDS patients;
- Treatment for STDs;
- Improving women's status to reduce their risk of infection;
- Providing more frank information about AIDS;
- Making plans in anticipation of the socio-economic impact of the pandemic, and
- Overcoming stigmatization and discrimination.

To improve efforts to fight the spread of AIDS and to prepare for increasing numbers of HIV cases, UN agencies agreed to co-operate in the new joint and co-sponsored United Nations Programme on HIV/AIDS (UN, 1994: 49). The effort would bring together the
work of six UN organizations – WHO, UNICEF, UNDP, UNESCO, UNFPA and the World Bank. WHO would administer the joint programme, which would incorporate ongoing activities. The expectation was that the joint programme would strengthen the worldwide fight against the pandemic at a country level (UNAIDS 2002).

In response to the escalating crisis, the Executive Boards of WHO, UNICEF and UNESCO approved a new joint and co-sponsored UN programme on HIV/AIDS, which would soon go to the Executive Boards of UNDP and UNFPA (UNAIDS, 2002). The co-sponsored program would promote co-coordinated fundraising at global and country levels and better integrate ideas and approaches among UN agencies.

For governments struggling to cope with the growing numbers of HIV infections and AIDS cases, the programme would provide a more comprehensive UN support and help them co-ordinate efforts of donor agencies. It would also ensure wider application on a global scale of prevention and control activities such as education programmes and treatment of sexually transmitted diseases (STDs). The most important objective of the programme would be to “reinforce national capacity to respond to the epidemic” especially through technical advice (WHO, 1994).

A number of problems cited by developing countries and donor governments led to the programme’s formulation. The global policies that had been agreed on were not being carried out effectively in some countries. Governments were receiving conflicting
technical advice, and there was confusion about the role of the various organizations involved in the fight against the AIDS pandemic (UNPI, 2001).

Meanwhile, multisectoral action and financial resources to fight the epidemic were still limited. Apart from these difficulties, continuing complacency about and denial of the pandemic, the growing impact of HIV/AIDS on women, the burden of the disease on health care systems and discrimination of infected people were among concerns demanding more co-ordinated action.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund has been operational since January 2002. It was set up as a financial instrument to complement existing funding for programmes addressing HIV/AIDS, T.B. and Malaria. The fund concentrates on generating additional resources and making them available at the community and country levels.

As a public-private partnership, the fund’s board includes official country representatives from both North and South, as well as representation from the business sector, NGOs and communities directly affected by the epidemic (World Bank, 2002). The fund co-ordinates its activities with governments, civil society, NGOs, UNAIDS, the private sector and donor agencies.

Total pledges to the fund stood at around US $2 billion in April 2002. Most of the pledged funds came from the endowments of major philanthropic organizations. The
first grants which the fund announced in the same month stood at more than US $616 million over two years to support programmes in over thirty countries to combat AIDS, T.B. and Malaria. Around 60% of these funds will support HIV/AIDS prevention and treatment programmes, and most of these grants specifically include funding to purchase antiretroviral treatment. A further 15% of funds will go to programmes to fight AIDS, together with Malaria and T.B.

Policies on Antiretroviral Drugs

The turning point in the effort to ensure wider availability for anti-AIDS drugs came in March 2001, when thirty-nine Northern pharmaceutical companies went to court in South Africa to block legislation permitting governments to lower the cost of AIDS-related medications – steps the companies asserted would infringe on their patent rights (UNPI, 2001: 9). The suit proved to be harmful to the images of the companies. A month later, due to worldwide protests and criticism, the companies withdrew their legal challenge and pledged to work with the UN on a drug access programme far broader than previously thought possible.

The new paradigm in access to care is beginning to take effect, and long-standing global inequities are being challenged. From disputes by the WTO, to court cases in Southern Africa, debate in relation to essential medicines is being considered in favor of lowering trade barriers to access (UNPI, 2001: 12). The principle of preferential pricing for HIV drugs for low and middle-income countries has been accepted by many pharmaceutical industries (UNAIDS 2002: 17). Prices have begun to drop and countries’ rights to invoke
compulsory or voluntary licensing arrangements on patented drugs and medications were affirmed clearly at the WTO meeting in Dohar, Qatar, in late 2001.

Generic versions of many antiretroviral drugs now exist. The WTO has begun a process of quality assessment of HIV medicines (brand-name and generic) and is widely publishing the results in order to promote rational use of drugs as well as affordable prices (UNAIDS, 2002:17)

In Africa, where the gap between needs and resources is greatest, advances are being made in the wealthier countries such as Botswana, Gabon and Nigeria, and in those countries still with relatively small HIV-positive populations such as Senegal. But in Uganda, infrastructural facilities necessary for the distribution of these drugs are still very limited especially in rural areas

However, the extremely high costs of the drugs put them beyond the reach of most people in the developing countries. It is also notable that the public health systems in poor countries are not able to cope with the complexity of the treatments and the need for ongoing testing and follow-up.

Although the discounts still price many of the medicines beyond Africa’s means, the reductions have transformed the debate about the costs – which the WHO has identified as the obstacles to wider availability of AIDS medicines.
Concerns about delivery in poorer countries have also been challenged. On 4th April 2001, more than one hundred medical and development experts of Harvard University in the US declared, “Objections to HIV treatment on low-income countries are not persuasive,” and issued a detailed blueprint for widespread treatment programme. “Poor infrastructure,” they asserted, “can be overcome through well designed and well financed international efforts” (World Bank 2002).

However, the study found out that antiretroviral drugs are still not accessible to the refugees at Kakuma Refugee Camp. In fact even if they were, many of the refugees who are HIV positive would not be able to afford them. This is because most refugees do not have any income generating projects / jobs and even the reduced prices of the drugs – around Kshs. 3000 per patient (Daily nation, May 13, 2003) are still beyond the reach of many.

**HIV/AIDS Control and Debt Relief**

Reducing the debt burdens of poor countries is also thought to be important in boosting the AIDS response where it is most needed (World Bank 2002). The debts of the thirty-eight highly indebted poor countries (HIPC), thirty-three of them in Africa, amount, on average to more than four times their annual export earnings. These debt burdens mean that annual debt servicing obligations can undermine countries’ social spending, including that required for their HIV/AIDS responses.
In 16 African countries in 2001, governments were still spending more on servicing debts than on the health of their citizens. The HIPC debt initiative devised by the World Bank and IMF is one attempt to relax those constraints and enable countries to allocate more resources to social development. Under the initiative, eligible countries qualify for debt relief if they meet certain conditions, including the adoption of economic adjustments and the drafting of poverty reduction strategies in which social spending is given priority (UNAIDS, 2002).

Applicant countries are encouraged to include HIV/AIDS programmes in these strategies. UNAIDS and its co-sponsors are working to provide technical and other support to help countries integrate HIV/AIDS into poverty reduction strategies (UNAIDS, 2002: 168).

Initial indications are that an average HIPC will spend about 25% of their annual interim debt relief on health care (UNAIDS, 2002). As for AIDS, data from ten low-income African countries from this group (Benin, Burkina Faso, Cameroon, Madagascar, Mali, Mauritania, Mozambique, Uganda, Tanzania and Zambia) suggest that, together, they were budgeting some US $32 million for AIDS activities on about 5% of their HIPC savings in 2001.

The UNAIDS Secretariat has reviewed the first generation of 25 full and interim Poverty Reduction Strategy papers prepared by Sub-Saharan African countries to gauge how well they were dealing with HIV/AIDS. The review was based on four criteria:

- Analysis of the relationship between AIDS and poverty has been carried out.
- The main strategies from the countries’ national AIDS plan feature in the poverty reduction strategy papers.
- Medium-term AIDS prevention and care goals and indicators for monitoring poverty are used.
- Short-term initiatives to fight HIV/AIDS that can be monitored have been incorporated.

In some other HIPC countries, however, little or no more from debt relief proceeds has been specifically allocated to HIV/AIDS. In addition, this source of funding is not available to several low and middle-income countries that are experiencing severe HIV/AIDS epidemic. Currently, there are sixteen countries that are ineligible for debt relief under the HIPC initiative. In these countries, adult HIV prevalence exceeded 1.5% in 2001. They include several African countries where HIV prevalence was above 20% in 2001 (World Bank, 2002).

It is notable that if funding for HIV/AIDS projects is pegged on international debt then refugee communities need a special concession since they are stateless people who do not benefit directly from any national policy on HIV/AIDS. However, this is not suggesting that the donor community is right in doing this.

Refugees in Kakuma are from eight states. All these states face the debt crises and even the host state – Kenya is concerned. The intervention against HIV/AIDS should be totally humanitarian and should be carried out without any conditionality.
The Role of the United Nations

Numerous organizations within the UN have become involved in the fight against HIV/AIDS. This is based on the realization that AIDS is not only a health problem but also a social, economic and development issue.

World Health Organisation

The WHO Global Programme on AIDS works with individual countries, helping them with short term measures for responding to the crisis and then with support for a national AIDS programme capable of taking on long-term prevention, control and care (WHO, 2002). Today, national AIDS programmes have been established in virtually every country of the world, most of them guided by the Global AIDS strategy which was updated in 1992.

GPA's mission is to mobilize an effective, equitable and ethical response to the pandemic. It strives to raise awareness, stimulate solidarity and unify worldwide action (WHO, 2002). It is also dedicated to strengthening of the capacity of countries and communities to prevent HIV transmission and reduce the suffering of people already affected. It provides technical and policy guidance to governments, other agencies and non-governmental organizations. At the same time, it promotes and supports research to develop new technologies, interventions and approaches to AIDS prevention and care.
Under the 1988 WHO/UNDP Alliance to combat HIV/AIDS and the 1992 "Memorandum of Understanding for the Implementation of the Alliance", UNDP's particular responsibility is to provide support in tackling the social and economic dimensions of the epidemic and minimizing its impact on human development (UNDP, 2000). More specifically, its mandate is to:

- Increase awareness of the development implications of the epidemic;
- Strengthen and expand the capacity of communities to respond to the epidemic;
- Promote and assist prevention, care, support and treatment programmes for women; and
- Assist governments to develop effective multisectoral HIV strategies and minimize the devastating consequences and widespread infection

United Nations Population Fund

UNFPA applies its thirty years' experience in reproductive health to prevent HIV and STIs. Within 150 country programmes UNFPA focuses on HIV prevention among young people, comprehensive condom programmes for both male and female condoms, and prevention of infection among pregnant women (UNFPA 2002). UNFPA supports:

- Advocacy efforts;
- Improving access to information and education, including voluntary counseling and testing;
- Strengthening capacity of service providers across sectors, and
- Providing commodities for the prevention of HIV and STIs, such as STI/HIV test kits, male and female condoms and infection prevention and control supplies.

United Nations Educational, Scientific and Cultural Organization

UNESCO's primary aim is to develop educational strategies adapted to different socio-cultural contexts that help young people adopt responsible attitudes and behaviour to avoid HIV infection (UNESCO, 2001). These strategies are then provided to decision makers and educational planners to assist them in developing programmes to prevent AIDS and STIs. It also develops advocacy material for school based AIDS education programmes such as the film called, "AIDS, It's Time for Schools to Act!" released in 1993 (UNESCO, 2001)

United Nations Children’s Fund

UNICEF also supports AIDS education activities – through school curricula, health education and other related outlets – to reach women and children at risk (UNICEF, 2002). It provides orientation and training for those likely to come into contact with AIDS patients or their relatives and promotes advocacy efforts to raise awareness and mobilize resources. It has worked to expand primary health care (PHC) networks and has placed particular attention on the sterilization of medical equipment. It is also examining ways to care for the growing number of AIDS orphans.
United Nations International Drug Control Program

The UNDCP is entrusted with the responsibility for co-coordinating and providing effective leadership for all UN drug control activities. In this context, it supports HIV/AIDS prevention through programmes that aim at reducing the demand for illicit drugs. Its primary focus is on youth and high-risk groups (UNDCP 2002).

International Labour Organization

ILO works to promote social justice and equality, set standards on employment and improve working conditions. It also has a tripartite membership that encourages the mobilization of governments, employers and workers against HIV/AIDS (ILO, 2002). It has produced a code of practice on HIV/AIDS and the world of work – an international guideline for the development of national and workplace policies and programmes.

The World Bank

The mandate of the World Bank is to alleviate poverty and improve the quality of life. Between 1986 and early 2002, the Bank committed nearly US $2 billion for HIV projects worldwide (World Bank, 2002). Most of the resources have been provided on highly concessional terms, including US $1 billion under the multi-country HIV/AIDS programme (MAP) for Africa. To address the devastating consequences of HIV/AIDS on development, the Bank is strengthening its response in partnership with UNAIDS, donor agencies and governments. The Bank’s response encompasses prevention, care, support, treatment and impact mitigation.
The Joint United Nations Programme on HIV/AIDS (UNAIDS)

UNAIDS is the leading advocate for global action on HIV/AIDS. It brings together eight UN agencies in a common effort to fight the epidemic (UNAIDS, 2002). All the agencies illustrated above (UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO, ILO and World Bank) join efforts to form the joint agency.

UNAIDS both mobilizes the responses to the epidemic of its eight co-sponsoring organizations and supplements these efforts with special initiative. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights.

UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to achieve knowledge, skills and best practice across boundaries.

United Nations General Assembly Special Session on HIV/AIDS

In June 2001, the membership of the United Nations met in a special session of the General Assembly to agree on a comprehensive and co-ordinated global response to the AIDS crisis. The members adopted a powerful “Declaration of Commitment” and reaffirmed the pledge (made by world leaders in the Millennium Declaration) to halt and begin to reverse the spread of AIDS by 2015 (UNPI, 2001).

The UN General Assembly Special Session on HIV/AIDS differed from the hundreds of meetings and summits held in the past twenty years since it was a meeting of all states,
acting as governments. As such, it yielded both a common mandate and a basis for political accountability (UNGA, 2001).

The Special Session’s Declaration of Commitment adopted unanimously now serves as a benchmark for global action. Debate at the Special Session revealed continuing differences between states on how to respond to marginalized groups, such as men who have sex with men, injecting drug users and sex workers. Nevertheless, the Declaration expressed unanimous approval of fundamental approaches to tackling the epidemic based on responses grounded in respect for human rights (UNGA, 2001).

The Declaration of Commitment provides the world with a basis for effective political action and a yardstick of accountability. At international, regional and national gatherings since the Special Session, the Declaration of Commitment has served to define agenda and create a common platform for action.

Complementing the Declaration of Commitment, a single United Nations strategic plan was adopted for the first time in 2001 (UNAIDS, 2002: 16). This brought together within the UN not only UNAIDS and its co-sponsors but HIV/AIDS activities from a total of 29 UN organizations and agencies.

The illustration above has clearly showed that UN is playing a leading role in the combat against HIV/AIDS within the global scene. The UN system is playing an all-rounded
role and using different strategies and approaches. It is leading in research issues such as the invention of AIDS vaccines and HIV testing technology.

The UN is also playing a key role in advocacy through conference and roundtable talks. It has also formulated international policies and guidelines for effective intervention. As far as funding is concerned, different UN agencies have specialized in specific HIV/AIDS issue areas such as the refugees.

However, the research found out that UN bodies are not implementing agencies. They depend on governments, INGOs, NGOs, IGOs, faith-based organizations and the civil society at large. The lack of technical staff in the field hampers the effectiveness and efficiency of their supported programs. On the other hand, it is also expensive to monitor all the assigned entities to implement the programs.

The Role of the Civil Society and Government Commitment

Growing political engagement in response to AIDS is grounded in two decades of AIDS activism, led by individuals and communities whose lives have been touched by the epidemic (UNAIDS, 2002, 11). Organizations as diverse as the Gay Men’s Health Crisis in New York, The AIDS Support Organization in Uganda, The Save Your Generation Association in Ethiopia, Grupo Pela Vida in Rio De Janeiro, and many hundreds of others like them, are built on the same foundations: an initially small group of people responding to the impact of AIDS by coming together to provide mutual support and take action (IACC, 2000).
Activist movements responding to AIDS now exist globally. They have many aspects:

- Community groups providing home-based care,
- Treatment activists working through media and the law courts to extend access to HIV drugs,
- Networks such as the International Council of AIDS Service Organizations and its regional bodies, and
- Associations of HIV-positive people nationally and internationally, together with positive women’s networks.

The presence of non-governmental and community-based organizations was notable at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, providing a sense of urgency and conscience to Member State deliberations (UNP1, 2001: 11).

The “Global Fund to Fight AIDS, Tuberculosis and Malaria” has modeled a new way of working by including on its board not only NGO representatives but also a seat for people that are directly affected. The background of activism sustained in communities motivated to take action against AIDS, is key in driving political momentum locally, nationally and globally.

From within the United Nations, Secretary General Kofi Annan has helped catalyze growing global engagement. In April 2002, at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, in Abuja, Nigeria, he issued a global call to action in the fight against AIDS. The personal priority he has given to AIDS has
helped energize the United Nations System, as well as engage political and business leaders in the challenge (UNAIDS, 2002 12)

At the Millennium Summit of the UN in September 2000, 43 heads of state and government, from both the countries heavily affected and those less so, he referred to AIDS as one of the most pressing problems worldwide. Presidents and prime ministers, particularly those from Africa and the Caribbean, but also those in Asia, Western and Eastern Europe are displaying a personal commitment to the fight against AIDS.

AIDS is now a prominent issue at international gatherings – both in the North and in the South. It has been on the agenda of summits and decision making forums of the G8 and G77 nations, the Organisation of American States, the former Organisation of African Unity, the Commonwealth of Nations, the European Union, the Association of South-East Asian nations, and the Caribbean Community Secretariat (UNAIDS, 2002).

Both the World Economic Forum and the World Social Forum (in Porto Alegre) have held key sessions on AIDS and its global implications. The UN Security Council held its first-ever debate on AIDS in January 2000—the first time it had it examined as a health or development issue. Since then, it has held two more public debates on AIDS (UNP1, 2001).

However, the study found out that most entities within the civil society are being accused of dishonesty and mediocrity in the running of their programs. Most NGOs consulted during the study did not have any documented information of what they do in the combat
against HIV/AIDS. It was also realized that most NGOs uphold such secrecy and confidentiality that they cannot avail any information to the public.

They are also accused of having huge program budgets – most of which are not directed towards the combat against HIV/AIDS. This seemed to be connected to the exaggeration of HIV/AIDS statistics so as to attract donor funding.

On the other hand, it is commendable that most of them are able to reach the grassroots where the actual problem is. Most of them have also forged joint efforts in addressing particular issue areas such as access to drugs, care, treatment and prevention. This is in spite of the fact that some are still acting as lone rangers. At Kakuma, IRC, JRS and NCCK have a loose collaboration – they are all involved in HIV/AIDS projects although there is no particular premise for collaboration.

**The Role of Faith-Based Organizations**

Faith-based organizations are playing an important role in responding to HIV/AIDS. In Africa, church supported hospitals and clinics were among the first to care for people who fell ill with AIDS. Faith-based organizations also have a key role to play in advocacy and prevention (UNAIDS, 2002: 178). In Africa for example, USAID provides grants to support the strategic planning and programme activities of a variety of religious networks, including the All-African Conference of Churches, The Organisation of African Instituted Churches, the Islamic Medical Association of Uganda, the Church of the Province of South Africa (Anglican) and the Uganda Interfaith Alliance.
Faith-based organizations have enormous influence over the cultural norms that guide individual and community behaviour and that affect how information about AIDS is interpreted (Okaalat, 2002). Some of them, for example the Catholic Church have objections to the use and promotion of condoms, preferring to stress the teaching of faithfulness and abstinence as prevention measures.

Such teaching can be effective in helping to change behaviour in positive ways, if people also gain the ability to adhere to it in their daily lives.

Other faith-based groups, such as the Islamic Community in Uganda, have publicly indicated that education on responsible use of condoms was acceptable (UNAIDS, 2002). Similarly, the Ecumenical Advocacy Alliance has illustrated in its action plan that sex education is a key tool for HIV prevention. It stresses that people need factual knowledge on sexual anatomy, physiology and psychology in order to be able to live safely in abstinence or fidelity.

Other organizations are involved in research and publication as way of combating the epidemic. The Medical Assistance Programme (MAP) is such one. Some are also involved in the distribution of and campaign for lower drug prices. The Ecumenical Pharmaceutical Network (EPN) is an umbrella body of such a kind.

Support for expanded AIDS responses has been voiced by religious leaders and groups of all faiths – from Catholic and Protestant bishops and the Patriarch of All Russia, to
associations of Imams and networks of Buddhist monks in South-East Asia (UNAIDS, 2002).

The research found out that there are two faith-based organizations that are involved in the combat against HIV/AIDS at Kakuma Refugee Camp. These are the National Council of churches of Kenya (NCCK) and Jesuit Refugee Services (JRS). Although JRS is a Catholic organization, it was found out that it is involved in the distribution of condoms, unlike most Catholic entities.

However, no Islamic organization is involved in the combat against the pandemic in the camp.

Sub-Saharan Africa – HIV/AIDS Policies

"AIDS is not an African problem alone." UN Secretary General Kofi Annan declared. "AIDS is a global problem. But if we do not win in Africa, we are not going to win anywhere else" (UNPI, 2001). He was speaking to African leaders, policy makers and activists who met in Nigeria to map out the continent's strategy to combat the disease that already had taken 17 million African lives and infected tens of millions more.

However, currently the political commitment to turn the tide of AIDS appears stronger than ever. Gatherings such as the 2000 African Development Forum meeting and the Organisation of African Unity Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in April 2001, appear to be cementing that resolve (UNPI, 2001). Several regional initiatives to roll back the epidemic are underway. Some, such as those
grouping countries in the Great Lakes region, the Lake Chad Basin and, West Africa, are concentrating their efforts on reducing vulnerability of refugees and other mobile populations.

Other initiatives are continent-wide, such as the International Partnership against AIDS in Africa (IPAA) and the Multi-Country HIV/AIDS Programme for Africa (World Bank, 2002).

**International Partnership against AIDS in Africa**

IPAA harnesses the strengths of its members (governments, the United Nations, donors and the private and community sectors) to enable it carry out its mandate. Within the first two years of its existence, it was able to realize the establishment of national HIV/AIDS responses. By 2002, nineteen countries had set up national HIV/AIDS councils or commissions at senior levels of government and local responses are still growing in number.

34 countries across Sub-Saharan Africa have completed national strategic AIDS plans. And another seven plans were in the formulation process in 2002. The main goal of the partnership is to urgently mobilize nations and civil societies to redirect national and international policies and resources to address the evolving HIV/AIDS epidemic and its implications. To achieve its goals, the co-sponsors agreed that the partnership would focus on the following main lines of action:

- Mobilizing high-level African political support
Widening the partnership to include African governments and other key constituent groups

Assisting African countries showing their commitment to the partnership to design and implement intensified national AIDS programmes

Mobilizing extra financial resources for intensified AIDS programmes at both country and regional levels, and

Strengthening technical resources to support national and local projects

The Multi-Country HIV/AIDS Programme for Africa (MPA)

Managed by the World Bank, the MPA came into effect in 2001. The programme takes the form of large zero-interest loans to support governments over several years. These loans are largely channeled as grants to communities and civil society organizations (World Bank, 2002: 168)

The emphasis is on increasing access to HIV/AIDS prevention, care, support and treatment programmes as well as mitigating the impact of the epidemic. The funding totals US $ 500 million and the first stage was approved by the World Bank in September 2001, and is now supporting 13 countries in Sub-Saharan Africa.

In February 2002, the Bank provided US $ 500 million more, which is expected to support another 12-15 countries (World Bank, 2002). In addition to country programmes, it is intended to support sub-regional and cross-border initiatives – for example, those targeting major transport routes such as the Abidjan-Lagos Corridor.
But it is not only the foreign community that is responding against HIV/AIDS in Africa. The African leaders themselves have taken initiative to address the issue nationally, regionally and continentally. An example of such an initiative is the Abuja Summit that was held in April 2001 in Abuja, Nigeria. The "African Summit on HIV/AIDS, TB and Other Related Infectious Diseases." was held as an implementation of the decision of the OAU heads of state and government meeting in their 36th Ordinary Assembly in July 2000 in Lome, Togo (NACC. 2001: 9).

They gathered to undertake a critical review and assessment of the situation and the consequences of the stated diseases in Africa, and to reflect further on new ways and means whereby they could take the lead in strengthening the ongoing successful interventions and developing new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at national, regional and continental levels with a view to ensuring adequate and effective control of HIV/AIDS, TB, and Other Related Infectious Diseases in the continent.

They recalled and reaffirmed their commitment to all relevant decisions, declarations and resolutions in the area of health and development and on HIV/AIDS particularly the "Lome Declaration on HIV/AIDS in Africa" (July 2000) and the decision on the adoption of the International Partnership against HIV/AIDS" (Algiers 1999). (UNPI, 2001: 20).
It is noteworthy that there are special intervention programs targeting Africa as a continent. Even though some of these programs are African-borne, there is a heavy presence of foreign dependence for the running of most of the programs.

It was revealed that most of the policies used in Africa are postulated by foreign entities such as UN bodies and other IOs. Most African governments have also not given HIV/AIDS the priority it requires in their annual national budgets. Most of them depend on donor funding for the programs that are already in place.

In fact, it took the intervention of the international community for the African states to establish national councils to co-ordinate the control of the pandemic in their own countries. It is even worse to note that African states have not done much to respond to the HIV/AIDS among refugees even though these refugees are African nationals who interact with the citizens of the host states and may later be repatriated to their home countries.

Policies Relating to HIV/AIDS among Refugees

The Abuja Declaration recognizes that forced migration due to war, conflict, natural disasters, and economic factors including unilateral sections imposed on some African countries, lead to an increased vulnerability and the spread of HIV/AIDS (NACC, 2001: 9). The African leaders noted that special attention should be given to migrants, mobile populations, refugees and internally displaced persons in national and regional policies.
The United Nations High Commissioner for Refugees (UNHCR), in accordance with the UN Special Session Declaration of Commitment on HIV/AIDS and the international Guidelines on HIV/AIDS and Human Rights, has adopted a rights-based approach in all its programmes and protection activities related to HIV/AIDS (UNHCR, 2002: 1).

In 2002, UNHCR availed a document entitled “HIV/AIDS and Refugees: UNHCR’s Strategic Plan, 2002-2004,” which illustrated two major objectives as the organization’s framework of action:

- Refugees and asylum-seekers live in dignity, free from discrimination, and their human rights are respected.
- Reduce HIV transmission and improve HIV treatment and care by:
  (i) Improving planning and implementation of HIV/AIDS programmes.
  (ii) Reinforcing surveillance, and monitoring, and evaluation of HIV/AIDS programmes.

For the realization of these objectives to be possible, UNHCR’s HIV/AIDS and Refugees Advisory Group laid down seven strategies to be pursued between 2002 and 2004:

- Ensure the effective implementation of UNHCR’s protection policy and standards at field level.
- Further consolidate UNHCR’s commitment to combat HIV/AIDS in refugee situations at all levels of the organisation.
- Reinforce access to qualified technical resources and strengthen institutional capacity building through partnerships.
- Continue to support current HIV/AIDS programmes.
- Develop comprehensive HIV/AIDS pilot projects in refugee situations through a phased approach targeting specific sites.
- Limited scope of UNHCR activities in returnee situations.
- Access additional financial resources by developing a specific section for HIV/AIDS activities in UNHCR’s annual programme budget.

The UNHCR Strategic Plan is global in nature and it is supposed to be used in all states of the world. The relevance and applicability of the stated measures can only be evaluated locally – nationally and according to the peculiarities of each refugee situation.

But UNHCR is not an implementing agency. It relies on other bodies, both governmental and non-governmental to carry out its strategies. One such organisation is an INGO called the International Rescue Committee (IRC). The main focus of IRC’s HIV/AIDS activities is disease prevention. Programme activities include health education and promotion, condom distribution, blood supply screening for HIV, treatment of sexually transmitted and opportunistic infections and ensuring that health staff follow universal precautions to protect their own health (IRC, 2000).

In several countries, voluntary counseling and testing for refugees and surrounding communities is also being planned. The IRC Health Care Strategy directs the combat against HIV/AIDS. The IRC Health Programme understands that vulnerability to STIs and HIV is determined not only by individual behaviour but also by the societal context and the quality and access to prevention, care and support services. It further recognizes
the importance of linking prevention with non-discriminatory care and support. It further acknowledges the need for co-ordination, collaboration, and communication within and among sectors and organizations at the camp in developing HIV/AIDS responses (IRC).

The research revealed that there is only one UN body that is directly involved with the issue of HIV/AIDS among the refugees. The others such as UNAIDS and WHO support the efforts of UNHCR through research, technical assistance and funding. However, even UNHCR is not an implementing agency. Thus, it depends on NGOs and Community Based Organizations (CBOs) for the implementation of its policies.

Just like the other UN bodies, UNHCR is in a way dependent on the good will of the host government during asylum or the home government after repatriation. It’s emphasize on the observance of human rights as a way of preventing and controlling HIV/AIDS is highly commendable but was found out to be facing both hidden and manifested obstacles. Individual refugees infected with HIV/AIDS live in communities that have diverse reactions towards them and also seek asylum in countries that have their own policies in regard to immigration and HIV – status.
CHAPTER THREE

THE CASE STUDY


Introduction

The previous chapter illustrated an overview of what international organizations are doing in the fight against HIV/AIDS globally, in Africa and among the refugee communities. This chapter looks at IRC, an international non-governmental organization that is involved in the fight against the HIV pandemic among refugees both globally and in sub-Saharan Africa. A critical analysis of its program at Kakuma Refugee Camp is the main issue of discussion.

It is notable that IRC operates within a global framework. Its operations at Kakuma fit within a global strategy (IRC Health Care Strategy). All its operations are within refugee settings, but it does not work on its own accord. It works under the mandate of the UNHCR – the leading international agency charged with all refugee operations. Furthermore, it also fits within the policy environment of the host states, which in this case is Kenya.
IRC also relies on donor funding for the support of its program at Kakuma. These donors are both national and international and have their own policies that guide their funding to organizations. It also works in close collaboration with other organizations.

It is against this diversified background that the IRC HIV/AIDS project at Kakuma is built. All the factors illustrated above have had a bearing on the program in all its spheres: the problem at hand (HIV/AIDS pandemic), and the nature and impact of the local, national and international responses against the scourge.

The study on the role of IRC at Kakuma in the fight against HIV/AIDS was guided by an investigation of the following factors:

- The spread of HIV/AIDS in refugee camps e.g. Kakuma;
- The response of IOs against HIV/AIDS among refugees such as IRC and UNHCR;
- The role of the government of Kenya in the fight against HIV/AIDS among refugees;
- The challenges faced by stakeholders involved in the fight against HIV/AIDS at Kakuma Refugee Camp;
- The impact of IRC’s work at Kakuma;
- The constraints to the work of IRC against HIV/AIDS at Kakuma;

The Spread of HIV/AIDS at Kakuma Refugee Camp

In sub-Saharan Africa, there are over 3.3 million refugees living in camps in 39 countries. Most of these refugees have either come from or sought refuge in a country
with high HIV prevalence (Spiegel, 2002:64) Spiegel illustrates that HIV prevention services in refugee camps have traditionally focused on general AIDS education/awareness but have not included specific prevention and care services.

According to UNAIDS and WHO (1997) survey, there are several factors which expose refugees to HIV infection. The first major risk factor is the lack of safe blood for transfusion during the flight from conflict. In the state of emergency, it is highly probable that the agencies involved in health intervention may use blood which is not screened. Also in situations of flight, women and girls are exposed to rape and sexual abuse. There is also the destruction of family ties and traditional values of chastity and self-control (UNAIDS and WHO, 1997:4)

Children who are not accompanied by their parents or close family relations are also exposed to early sexual activities. On the other hand, some refugees are involved in prostitution as a way of gaining material assistance.

All the above-mentioned factors apply to the situation in Kakuma. However, the next factor which is the sharing of needles by drug users does not apply because this practice is not common among the populations present within the Kakuma camp. UNAIDS/WHO survey found out that the interaction of refugees with the local population also exposes them to HIV infection (Spiegel, 2002:64). However, as much as these assertions cannot be ignored in relation to Kakuma, it is notable that Turkana district has so far remained a low-level infection area, thus, may not expose as much danger.
It is also illustrated that lack of access to condoms and to health is another major risk factor (UNAIDS/WHO 1997:49). The research found out that the Sudanese, 80% of the camp population do not like using condoms because they are aiming at getting as many children as possible to replace the part of the population that died in the way.

The presence of HIV/AIDS at Kakuma can be traced back to the very date of the establishment of the camp. Around 1990, approximately 17,000 “Lost Boys of Sudan” left their homes to find safety—some wandered in Sudan and Ethiopia for several years. About 10,000 "Lost Boys" eventually made it to Kakuma (Spiegel 2002:64). Only 2 HIV positive out of 3,600 boys screened for resettlements.

Between April and October 2002, 1602 persons were counseled. The majority of the clients were youth between 16 - 25 years (63%). Out of the numbers that were tested for HIV/AIDS, 375 were female and 1229 were male (Mwanyika, 2002). Among the females, 22 (5.9%) were HIV positive while 21 males (1.7%) were HIV positive. 75% of HIV positive people were less than 30 years of age.

From the camp health system, it was estimated that HIV/AIDS prevalence was 5% among pregnant mothers in 2002 (antenatal surveillance), blood donor screening (3.9%), VCT (2%), STIs Sentinel Surveillance (9%), TB patients (28.3%) and ANC syphilis (7%). The prevalence of 5% among the antenatal women is considered as an appropriate
estimate of the level of the disease among adult population 15 – 49 years (Mwanyika, 2002: 24).

According to a 2002 report delivered at ‘Tri-country HIV/AIDS and Refugees workshop’ in Entebbe, Uganda, if it is assumed that the situation was stable (mortality is equal to incidence of the disease) among the 32,000 adults in Kakuma, 1,600 were expected to be HIV positive (Mwanyika 2002: 24). From the 3,000 deliveries in 2002, 150 were excepted to be HIV positive. Assuming transmission from mother to child is 25%, 40 of the children born to the mothers were HIV positive.

While the yearly incidence of the disease is not yet known according to IRC, if we assume an incidence of 0.4% yearly (IRC 2002), about (0.4 x 32,000) or about 128 new cases are expected from the current Kakuma population every year.

The study revealed that IRC has used the prevalence among the antenatal women (15 – 49 years) of 5% as the approximate level of HIV/AIDS infection at Kakuma Refugee Camp.

**HIV/AIDS at Kakuma – The Response of International Organizations**

**UNHCR and HIV/AIDS at Kakuma**

Both the international and national response against the HIV/AIDS pandemic at Kakuma is guided by the UNHCR policy, “HIV/AIDS and Refugees: UNHCR’s Strategic Plan – 2002 – 2004.” This strategic plan is based on UNHCR’s policies, and technical and
normative guidance from UNAIDS and WHO (UNAIDS/WHO, 1996). In accordance with the UN Special Session Declaration of Commitment on HIV/AIDS (UNGA, 2001) and the international guidelines on HIV/AIDS and Human Rights (UNHCR/UNAIDS, 1996). UNHCR adopts a right-based approach in all its programmes and protection activities related to HIV/AIDS.

The UN General Assembly at its special session called on states, by the year 2003, to enact, strengthen or enforce as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and to develop strategies to combat stigma and social exclusion connected with the epidemic (UNGA, 2001).

At Kakuma Refugee Camp, just like any other similar setting, UNHCR plays the role of overseeing all the activities of the organizations involved. UNHCR itself is not an implementing agency, therefore it has given IRC the mandate of taking care of the health program at Kakuma. However, it (UNHCR) funds some of the running programs. It is one of the donors of the IRC’s HIV/AIDS program at Kakuma.
The study realized that UNHCR has only one medical officer who is in charge of both Kakuma and Daadab. This officer meets on a monthly basis with the HIV/AIDS program leaders within the camps. This is done as a form of coordination to ensure the efficient running of the programs. There is also a protection officer who is charged with the rescue of victims of violence (even sexual violence) within the camp.

Given that UNHCR is not directly involved in implementation, it is not able to appropriately evaluate the application of its policy of protection against HIV/AIDS infection through risk-related violence. The study found out that some communities within the camp force their members into activities that expose them to HIV/AIDS. It was revealed that some Sudanese communities practice wife and husband inheritance whereas some Somali clans practise female genital mutilation. All these contravene the UNHCR’s objective of empowering refugee awareness training in order to reduce their vulnerability to HIV/AIDS (UNHCR, 1995).

As a major donor agency for all refugee operations, UNHCR faces major budget deficits for its operations in Kakuma and elsewhere in Africa. It was revealed that targeted donor funds for sub-Saharan Africa get diverted when there are major immediate news such as the war in Afghanistan in 2001 and the one in Iraq in 2003.

On the other hand, it was revealed that UNHCR’s mandate in Kenya is so over-stretched that it is not able to effectively handle what it is required to do (Andamba, 6th June 2003.
Ministry of Home Affairs, Nairobi) UNHCR cannot force the implementation of its policies, but depends on the goodwill of the governments and hosts' states.

**IRC and HIV/AIDS at Kakuma**

In August 1992, at the request of the United Nations Operations Lifeline Sudan (OLS), UNHCR and the Kenya Government, IRC initiated a primary health care program in Kakuma Camp (IRC, 2000). In 1995, in response to the refugee needs, and in coordination with UNHCR, Lutheran World Federation (LWF), Jesuit Refugee Services (JRS) and other INGOs, IRC's activities expanded to include community based rehabilitation, self-reliance initiatives including adult education, micro-enterprise and community based rehabilitation.

IRC was mandated by UNHCR and OLS because both of them are non-implementing agencies. They rely on other organizations, especially INGOs of which IRC is one to run programs on their behalf.

The research found out that IRC launched an integrated program right from the beginning. In January 1997, it assumed responsibility for the camp hospital, bringing all preventive and curative health sector activities under its management. HIV related programs of STI control and treatment, condom distribution and the screening of blood for the HIV-virus were part and parcel of its practices. However, it was not until August 2001 when a full-fledged HIV/AIDS program was proposed and forwarded to the Centers of Disease Control (CDC) for funding consideration. The major donors of the IRC
HIV/AIDS program at Kakuma are UNHCR, CDC and the National AIDS and STI Control Program (NASCOP) of the Ministry of Health.

IRC works within a global framework whose major strategy is to ensure that basic HIV/AIDS prevention measures are in place in all its country programs. The key elements of an effective HIV/AIDS prevention strategy includes condom promotion and availability, effective case management of Sexually Transmitted Infections (STI), Voluntary Counseling and Testing (VCT), provision of a safe blood supply for transfusion and enforcement of universal precautions for health workers (ICR, 2001).

The above factors correspond with those recommended by UNAIDS as the best strategies for the prevention of HIV/AIDS among refugees (UNAIDS, 1997:60). In addition to what IRC has considered, UNAIDS recommends provision of basic HIV/AIDS information, physical protection of refugees, harm reduction where there is drug injecting victims, materials in schools, promotional campaigns and planning, and advocacy and communicating between the implementing agencies and the host community and country (UNAIDS, 1997: 6).

As was illustrated in chapter 1, IRC’s HIV/AIDS program works within the context of UNHCR policy on HIV/AIDS, Kenya National AIDS Strategic Plan and Policy (2000 – 2005), CDC Global AIDS Plan –Kenya Life Plan and the IRC Health Care Strategy. According to UNHCR, all refugee operations must respect and protect human rights (UNHCR, 2000) Responding to the HIV/AIDS epidemic should be seen as part of
meeting refugees' basic rights to life, health, education and information. Refugees also have a right to freedom from violence, including sexual and gender based violence. Coercion and discrimination, including mandatory testing, are not justified (UNHCR, 2002). IRC's program thus recognizes that violations of human rights increases vulnerability to HIV and that responses to HIV/AIDS if not well planned may breach human rights.

On the other hand, the declaration of HIV/AIDS as a national disaster in Kenya by President Daniel Arap Moi and the formation of the National AIDS Control Council (NACC) provide for all sectors and stakeholders of which IRC is one, to deal with numerous challenges presented by AIDS. The National AIDS Control Program (NASCOP) in Kenya has elaborated the National Strategic Plan and Policy 2000 – 2005 for HIV/AIDS/STDs which identifies response against the 'national disaster' (Office of the President, 2000) as:

- Advocacy and promotion of behaviour change
- Continuum of care and support
- Mitigation of the socio-economic impact of HIV/AIDS
- Epidemiology and research
- Prevention of mother to child transmission of HIV
- Management and coordination

The CDC, a major donor of IRC's HIV/AIDS program in conjunction with the Government of Kenya, donor agencies and key implementing partners have sought to
work with partners to reduce HIV infection and its impact through primary prevention, care, support and institutional strengthening to cope with the long term effects of the epidemic at all levels and in all sectors. The program targets among others, increased prevention efforts for groups at risk of infection, such as refugees, and expansion and improvement of prevention programs for youth and young people in the rural areas, for example Turkana region where the refugees are hosted.

The IRC and CDC collaboration against HIV/AIDS at Kakuma affected the designing of a comprehensive HIV prevention and care program in 2001. The project was designed to reduce HIV incidence and to provide assistance to refugees living with HIV/AIDS (Mwanyika, 2002:64). CDC provides HIV test kits, technical assistance, training and funding for the project. It is notable that refugees and host community are involved in the design of the project and service provision.

The IRC’s HIV/AIDS program has one major goal and eight objectives. Its goal is to increase the capacity of the health system, communities and other partners to establish an integrated and comprehensive health care and support system for people infected with and affected by HIV/AIDS. The eight objectives of the program corresponds to the recommendations of the UNAIDS (UNAIDS, 1997:2) for the prevention and control of HIV/AIDS among refugees.
IRC’s HIV/AIDS Program Objectives and Activities

The objectives that IRC is pursuing in its attempt to prevent and control HIV/AIDS at Kakuma Refugee Camp are as follows:

To build on and strengthen the existing diseases surveillance system in order to generate and share quantitative and qualitative data on HIV/AIDS and STIs. The epidemic in Kakuma camp is still at a low level (5%) compared to the projected national prevalence rate of 18% by the year 2000 (NACC, 2000:21).

However, several factors previously described which are unique to the camp may increase the risk of the spread of HIV. IRC has established a surveillance system based on ‘Second Generation Surveillance Guidelines’ and is trying to use the information gathered to inform future prevention efforts. Surveillance data is also shared with the refugees to help them mobilize to act against the spread of HIV and cope with its consequences. The project focuses surveillance efforts on tracking behaviour and markers of risk among the refugees. The surveillance officer of the Ministry of Health – NASCOP has visited the program and set up the sentinel site.

The second objective is to avail quality and accessible routine HIV diagnostic testing particularly aimed at TB and STI patients. Worldwide, TB is the major killer of people living with AIDS (PLWA). In addition to strengthening the current TB treatment program and harnessing the COR contributions to ensure that every PLWA (People Living With AIDS) with TB has access to effective TB treatments, IRC has availed and made accessible routine diagnostic HIV testing. This is available and accessible to the
youth and other vulnerable groups. However, the syndromic approach does not include HIV as an STI due to lack of symptoms at the early stages.

IRC also strives to avail quality and accessible HIV Voluntary Counseling and Testing (VCT) in the camp. Two VCTs have been established to facilitate acceptance and coping with ones sero-status, keeping HIV negative those who test negative (facilitating safer sex and reducing the risk of HIV transmission on HIV negative people). IRC also uses the VCTs to encourage behaviour changes in both infected and non-infected beneficiaries. IRC has also developed support groups for those affected by the disease, and has used the VCTs as private and confidential counseling discussions.

For effective implementation of VCT services, a full-time HIV/AIDS counselor has been hired to provide services and serve as a focal point for project implementation. The work of the counselor is to provide pre and post test counseling and ensuring that individuals and families have access to all available resources namely: Test kits; reliable testing procedures; links to services for HIV/AIDS care and support; and to social and psychological support services.

IRC also conducts community awareness, education and mobilization to ensure that those wishing to be tested understand what the test process is and where testing may be undertaken. It is also to ensure that those who are tested and found to be positive for the disease are provided comprehensive care rather than being discriminated against.
IRC’s other objectives is to establish an essential HIV/AIDS clinical care packages appropriately linked to the VCT services. IRC considers the development of networks of services and resource for taking up onward referrals from counseling to be essential in the development of VCT services. The network of services include:

a) Psychological support for PLWA and their families. As part of this care package, psychological support include counseling, spiritual support, support to enable disclosure and risk reduction strategies, medication adherences, and of life bereavement support. Peer support groups have been established to include those infected and affected by HIV, including the caregivers themselves. These support groups act as the focus for education, training and emotional and material support. The involvement of people affected by HIV/AIDS is used as a vehicle for generation of psychological support in affected families/communities.

b) Palliative care-This is done through the management of physical symptoms – pain, cough, skin rashes, fever, diarrhoea, depression, suicidal thoughts and other psychological problems. This also comprises spiritual support and bereavement counseling in collaboration with JRS.

c) Prevention and treatment of common HIV related opportunistic infections

HIV related opportunistic infections (based on the essential drug list by WHO/UNHCR) are being used to prevent and treat the common HIV related diseases.

d) Nutritional care-Dietary supplements are provided to prevent side effects and specific symptoms of some drugs used for treatment of opportunistic infections. As wasting and nutritional deficiencies are important adverse features of HIV
infection, food supplements are provided to prevent or treat wasting in conjunction with nutritional assessment, nutritional counseling and education.

It is also the objectives of IRC to consolidate and strengthen the existing TB and STI control initiatives to deal with the growing epidemic resulting from HIV infection. The project has intensified care finding and treatment for TB: with the current diagnostic facilities in the camp hospital, IRC has found it possible to exclude active TB and ensure appropriate monitoring and follow-up through the community outreach network. Increased support to the TB control program is being ensured in order to provide a coherent response to the dual TB/HIV epidemic.

STI intervention is also considered important as the majority of HIV infections in the camp are sexually transmitted. The prevention of STDs involve promotion of safer sex as well as early and effective case management and finding. It is for this reason that STI services and condom distribution have been consolidated and strengthened. Condoms are availed in the hospital, clinics and also in the market area, food distribution centres, water collecting points and social centres. Simple illustrated instruction leaflets are available where condoms are distributed.

IRC has also planned to produced and disseminate Behaviour Change Communication (BCC) materials. These BCC materials will be adapted with the participation of the refugee communities – posters, pamphlets, drama, puppet shows, song radio, videos, and newsletters. Messages in these materials will relate to safer sex practices (abstinence, use
of condoms), encouragement to seek treatment for STIs, and encouragement of respect and protection of women. Some married women and youth have been trained (and some more will be) as peer educators and Community Health Workers to conduct prevention counseling.

The management of STIs also include: Early and effective case management, partner notification and preventive VCT, refresher training of staff on STI treatment protocols using the WHO/UNAIDS curriculum; A consistent supply of the essential drugs and condoms; and programs monitoring for the quality of STI case management to include STI testing in ANC.

Another objective is to enhance the capacity of the community to identify risky behaviors, develop prevention strategies and manage community home-based HIV/AIDS care systems. HIV/AIDS being a chronic condition and given budget constraints, curative health facilities cannot be expected to cope with increasing number of HIV cases. It is therefore essential to recognize that PLWA will not always require hospitalization. Care within their families is more appropriate at some stage of their disease, provided that the individuals needs can be addressed outside the hospital. According to IRC, community-based care does not only provide a more cost-effective option, but also allow HIV positive individuals to receive care within their community networks.

First, IRC conducts a series of HIV strategy workshops in communities to combat negative stigmas and develop context and ethnic specific approaches to the prevention of
HIV in the camp. Opportunities are provided for social activities for adults and youths through the Multi-Purpose Centres (MPC) in the camp although these are still weak. Facilitators have been trained to conduct community discussions using participatory learning and action exercises for community behaviour and attitude change. The established linkage with the community is aimed at strengthening referral between the levels of health care and the community.

Secondly, home-based care has been established as part and parcel of the comprehensive care for PLWA in a continuum of care from the medical facilities to homes and vice versa. This is aimed at breaking down stigmas and barriers often associated with HIV infection and enabling communities to recognize that prevention needs to be a focus. Communities have been organized, trained and supported to ensure that services are effectively implemented and used.

Another objective is to minimize nosocomical infection with HIV/AIDS within the health facilities by institutionalizing universal precautions to improve blood safety. Universal precautions are important to prevent transmission of HIV between health workers and the refugees. The main risks to health workers are: injury with a needle or sharp instrument which has been contaminated with blood, exposure of open wounds to infected blood or body fluids on to mucus membranes and eyes. The main risks to the patients are: contaminated instruments, transfusion with contaminated blood and exposure of open wounds to infected blood.
IRC has tried to ensure universal infection control precautions through provision of required supplies and training of health workers on universal infection control precautions such as hand washing, safe handling of sharp instruments, safe disposal of medical waste including sharps, and decontamination of instruments and equipment. Also, measures to ensure the safety of blood transfusion are being applied. All donated blood is tested for HIV and other infectious agents. Clear policies and protocols have been adapted on the appropriate uses of blood for transfusion, the recruitment of donors, and the safe disposal of potentially dangerous waste products such as used blood bags, needles and syringes.

The last objective that IRC is pursuing at Kakuma is the prevention of mother to child transmission (PMCT). Interventions focused on mothers attending health services have been implemented. This includes advice on unprotected sex with non-regular partners, condom promotion, and management of STIs, community education, and access to the VCT, and strict criteria for transfusion.

Reproductive health services have been strengthened by adapting the family planning strategy that aims to guarantee and improve the future of their family, including spouses and children. This is also aimed at reducing mother to child transmission and training health workers to counsel mothers with HIV related signs and symptoms about their risk of PMCT.
The provision of HIV testing services to pregnant mothers provides a foundation for all PMCT activities. Knowledge of sero-status allows specific intervention in the current pregnancy and informed choices for subsequent fertility.

The above analysis offers the picture of what IRC is actually involved in at Kakuma in combating HIV/AIDS. On the other hand it is notable that IRC does not work alone. It collaborates closely with two religious organizations, namely the NCCK and JRS.

The Role of NCCK and JRS as Partners of IRC

The Kenya National HIV/AIDS Strategic Plan (2000 – 2005) recognizes the role that religious institutions play in the fight against HIV/AIDS. The involvement of religious institutions is essential to the successful implementation of the plan (NACC, 2000:17). The issues of condom use and family life education in schools are controversial, and religious beliefs in Kenya are diverse. However, all religious institutions have a common interest in the well being of the Kenyan population.

At Kakuma Refugee Camp, NCCK targets youth for HIV/AIDS prevention initiatives whereas JRS provides some basic counseling to HIV positive individuals. Both of them are also involved in the distribution of condoms. However, JRS still does not have a full-fledged program on HIV/AIDS.

Although the three organizations are working in close collaboration in the fight against the HIV/AIDS pandemic, they do not operate within any established framework.
There is an overlap of efforts since they are all involved in doing almost the same things (condom distribution and counseling). Apart from these two organizations, IRC also operates within a national framework of policies and mandates developed by the government of Kenya.

**The Government of Kenya and HIV/AIDS among Refugees at Kakuma Refugee Camp**

As indicated earlier, Kakuma Refugee Camp was established in 1992 at the request of the Government of Kenya, UNHCR and OLS. IRC was then charged to manage the health program within the camp. So far, it is established that the Kenya Government has played only a minimal role of seconding health officers to IRC to gain experience of health issues in refugee settings.

Even though NASCOP officials helped in carrying out a surveillance analysis on HIV/AIDS in the camp, the utilization of the derived information lay only with UNHCR, and the organizations it has mandated to establish HIV/AIDS programs.

NASCOP is also supposed to be carrying out a regular visit of the HIV/AIDS program at Kakuma to ensure adherence to national standards on HIV/AIDS control protocols but this has not been effective. NASCOP has also not lived up to its mandate of supplying condoms to IRC as it is supposed to do to all HIV/AIDS programs within the country (Ministry of Health, 2001:34). Even the National AIDS Control Council (NACC) has not coordinated with the camp authorities HIV/AIDS programs even though it has a District AIDS Control Committee (DACC) in Turkana where the camp is located.
Infact no mention has been made of refugees as a community in the strategic plan, which means that the mandate of controlling HIV/AIDS among refugees still does not exist within the national framework. This is in contrast to the articles of the Convention Relating to the Status of Refugees of the 28th July, 1951 and the 1967 protocol thereto; and the Articles of the Organization of African Unity Convention Governing Specific Aspects of Refugee Problems in Africa of the 10th September, 1996; (copies all of which international instruments are set out in the third schedules); and are supposed to be subject to all laws in force in Kenya.

The analysis of the HIV/AIDS problem at Kakuma Refugee Camp and the nature of response – international, national and local – reveal that there are several challenges that IRC is facing in its attempt to fight against the pandemic in the camp.

**Constraining Factors to IRC’s HIV/AIDS Program at Kakuma**

The first factor that is challenging the efforts of IRC is the implementation of the UNHCR policy on HIV/AIDS. As indicated earlier, this policy ties the observance of human rights with the prevention, control and care of HIV/AIDS cases. For this observance to be possible, the entire community of individuals and organizations involved must understand the policy and practice it willingly.

However, the study revealed that stigma and discrimination against those who are infected is still rampant within some of the communities (especially the Somalis) within the camp.
It was also revealed that among all the countries that most refugees apply to for resettlement, it is only USA that accepts entry for the HIV positive refugees. This means that the others use HIV-positive status of refugees to deny them asylum. However, UNHCR as an IO is limited and cannot force states to observe international instruments.

The other challenge is related to IRC itself. Its approach of training the refugee community and hiring some to coordinate the HIV/AIDS program has been thwarted by the nature of mobility of the refugees. The study found out that there is a high turnover of staff because many of them are resettled in other countries time after time. The outcome of this is the hindrance to capacity building within the camp and also lack of continuity in the management of the HIV/AIDS program.

The financial implication of this is the fact that funds committed to the training kitty continues being used without much long lasting benefit to IRC as an organization, to the HIV/AIDS program and to the refugee community at Kakuma.

The other challenge has to do with cultural dynamics and responses to the prevention measures. The Sudanese communities reportedly disapprove the use of condoms as they think that it will hinder the growth of the population. They want to get as many offsprings as possible so as to replace those who died in the war. They also practice wife and husband inheritance. This poses an infection risk if at all the widowed party’s partner has died of HIV/AIDS.
The Somalis on the other hand still strive to practise female genital mutilation. If the equipments used for such are not disinfected, the victims stand a risk of contracting HIV. They also look down upon those who are infected. This hinders IRC's effort of encouraging home-based care since the HIV/AIDS patient is considered an outcast.

There is also a problem of infrastructural development. There is lack of investment in proper facilities. For example, poor support to laboratory services for diagnosis and monitoring of HIV and HIV related diseases. There is inadequate training of health workers on HIV/AIDS/STD response, irregular and inadequate availability of drugs, reagents, equipment and other commodities needed for HIV/AIDS care and support. In fact, there are only two VCTs in this camp which are meant to serve a population of about 86,000 refugees and even the local Turkana population.

The other constraint is related to the Kenya Government. It is notable that even though refugees started flowing into Kenya in early 1970s, the government has so far not laid down any legislative guideline to direct the refugee operations. The pending “Refugee Bill 2003” is going to be the first of its kind. Therefore, the refugee operations in Kenya are guided by UNHCR policies and at times presidential and ministerial decrees. This is the reason why the government has not fully committed itself in the fight against HIV/AIDS among the refugees. The procurement procedures that the IOs have to go through are long, bureaucratic and tedious.
The refugees are so far not allowed to hold employment. This encourages a state of dependence on relief handouts which are not enough for families. In a state of poverty and helplessness, such refugees involve themselves in commercial sex so that they can earn a living. This practice exposes the refugees to HIV infection. The government also does not allow the refugees to move freely out of the camp. This further hinders their prospect of engaging in commercial businesses. It still leads to a state of poverty with its risk-factor consequences.

Another challenge to IRC's HIV/AIDS intervention is the mobility of refugees between Kakuma, Lokichogio and Sudan and their interaction with the local Turkana community. The study found out that individual refugees visit Sudan voluntarily to check on the war situation and also interact closely with locals. Even though both Turkana and Southern Sudan are still low infection areas it cannot be ruled out that there is a danger of infection to all parties. The danger to the program is that it is not easy to control the spread of HIV/AIDS within the camp if in and out mobility is high.

The Impact of IRC HIV/AIDS Program at Kakuma

According to the National AIDS Control Council (NACC, 2000:2), HIV spreads rapidly in Kenya through sexual contact (90%) of infections. Mother-to-child transmission and contact with blood accounts for the other 10% of transmission. Adult prevalence rose from 5.3% in 1990 to 13.1% in 1999. Prevalence is higher in urban areas (about 11 to 12%). 80 to 90% of infections are among young people aged 15 – 49 years.
On the other hand, the levels at Kakuma are as follows: blood screening (3.9%), VCT (2%), STI sentinel surveillance (9%), TB patients (28.3%), pregnant women (5%), mother-to-child transmission (25%). The national level was around 13.1% in 1999 (NACC, 2000:22), and had gone down to around 6.5% in 2002 (Mwanyika 2000:24), whereas other rural areas stood at 11 – 12%. The annual rate of spread at Kakuma was approximated to be 0.4% in 2002.

The above analysis shows that the intervention measure against HIV/AIDS at Kakuma by IRC and its partners have significantly managed to control the spread of HIV/AIDS in the camp. This is considerable given that the camp was established in 1992 when the rate of the spread nation-wide was already 8% (NACC 2000:3).

The impact of IRC’s HIV/AIDS program is attributable to its integrated approach – whereby the HIV pandemic is tackled as a social, economic, cultural and health problem. The social aspect of counseling and community mobilization has strengthened awareness of the disease and encouraged the acceptance of intervention measures such as VCT services. Economically, IRC also does capacity building through adult education and small-enterprise business skill impartation. This to an extent ensures income generation to refugees and helps in prevention of prostitution – a practice which exposes individuals to the risk of HIV infection.

IRC also acknowledges the role of cultural values that instill moral principles. Through this, it has trained community based peer groups which are meant to advocate behaviour
changes. As a health need, IRC's program carries out prevention, control and care – the 3 major intervention measures against the pandemic. However, it is notable that the successful impact realized by IRC would not have been possible without the policy support, funding and collaboration in implementation of the HIV/AIDS program by different organizations. In fact, if the challenges analysed earlier are appropriately tackled, the program will be more effective and efficient.
CHAPTER FOUR

The Impact of International Policies in the Fight against HIV/AIDS among Refugees in Sub-Saharan Africa.

Introduction

This chapter offers a critical analysis of the policies that have been put in place by IOs in their attempt to combat HIV/AIDS among refugees in sub-Saharan Africa. It attempts to verify the level of impact of such policies on the African continent since most of them are international in nature. It highlights both the strengths and the weaknesses of the particular policies as far as their application in sub-Saharan Africa is concerned.

The chapter deals with topical issues on HIV/AIDS among refugees, the particular international policies used by IOs to address those particular issues and their application and impact in the intervention programs. It presents an analysis of the global policies in Chapter 1 and those in Chapter 2 and how they have been applied at Kakuma Refugee Camp.

This chapter looks at various policy issues and measures their impact against the stated hypotheses in chapter 1. The particular policy issues looked at can be grouped as:

- Prevention, control and care.
- The collaboration, co-ordination and co-operation of IGOs, INGOs, governments, faith-based organizations, and refugees living with HIV/AIDS.
- Financial resources.
• Stigma and discrimination
• Gender and HIV/AIDS
• Mandatory HIV testing of refugees

It is notable that the discussion of all the above stated factors is handled from the global level down to the Kakuma Refugee Camp.

**HIV/AIDS among Refugees – Prevention, Control and Care**

According to WHO and UNHCR (1995:33), the rationale for intervention against HIV/AIDS among refugees is based on the realization that the AIDS pandemic spreads fastest in conditions of poverty, powerlessness and social instability that generally prevail among refugees.

The vast majority of HIV infections in refugee situations are sexually transmitted (WHO/UNHCR, 1995:35). The disintegration of community and family life leads to the breakup of stable relationships and the disruption of social norms governing sexuality. Both children and adults may be coerced into sex to gain access to basic needs such as shelter, security, food and money. In situations of war, civil strife, flight and refugee circumstances, women, children and men are all at increased risk of sexual violence including rape.

In refugee situations, breakdowns in the normal systems of blood screening and universal precautions may occur (WHO/UNHCR 1995:33). In this case, HIV is transmitted by
transfusion of infected blood and blood products by the sharing of contaminated needles and other skin piercing instruments.

Vertical transmission, from mother to infant, may also occur. In developing countries, it is estimated at 25 - 30% and 15 - 30% in industrialized countries (WHO/UNHCR 1995:33). A proportion of this transmission will be through breastfeeding.

The interaction between the refugees and the local population also pose a danger of infection either way, depending on the general level of infection of both the refugees and the local population. Mandatory HIV testing of refugees is sometimes requested in the mistaken belief that this will help to prevent HIV transmission.

The above illustration is the background against which any intervention measure against HIV/AIDS among refugees is supposed to be built according to UNHCR and WHO. In 1995, UNHCR and WHO developed a field manual, "Reproductive Health in Refugee Situations," to act as a policy guide for all the stakeholders in this area. According to the manual, three activities should be carried out immediately prior to any assessment in any new refugee situation (UNHCR/WHO 1995:34).

The program should guarantee availability of free condoms, enforce respect for universal precautions against HIV/AIDS transmission in health care settings and identify a person responsible for the co-ordination of activities. However, comprehensive protection
against STD, including HIV/AIDS, should be made available to refugees at the earliest time possible.

**Assessment**

Before any HIV/AIDS program among refugees is established, there should be a thorough assessment of the spread and impact of the pandemic.

Assessment is a major policy issue as far as the intervention against HIV/AIDS among refugees is concerned. The challenge however is the fact that refugees flow in and out at different times. For example, at Kakuma Refugee Camp, it was the Sudanese who came in first and then later joined by other nationalities. This is because the conflicts that lead to the flight of refugees occur at different times.

This makes the gathering of appropriate information on the spread of HIV/AIDS among the various groups hard. Also, others get resettled soon after. This leads to inconsistency in the available information on the levels of the spread of the pandemic.

To plan an appropriate and comprehensive program, a situation analysis will have to be carried out as soon as feasible (Spiegel, 2002:1). Particular crucial information should be collected. The prevalence of STDs and HIV in the host and home country, region or area should be established (this information is normally available from the National AIDS Programs and WHO).
The study found out that IRC used the documented data on the levels of spread of the pandemic in the states of origin of the refugee groups. However such information had a lot of inaccuracy since by 1992 most of African countries had not carried out proper national surveillance on the pandemic.

There was still a lot of assumption, for example, Sudan was and is still considered a low infection area yet not much has been done to establish proper trends of the pandemic. In fact most of the refugees that settled in Kakuma had passed through other states such as Uganda where the disease was already prominent.

Even though IRC started its operations at Kakuma Refugee Camp in 1992, it was until the year 2001 when such a surveillance analysis was carried out. This is because HIV/AIDS was considered and handled as any other health issue. Efforts against HIV/AIDS were ran through the established health system. Prevention efforts such as the treatment of STIs and distribution of condoms had been going on from the start of the camp operations.

The limitation to this policy is the fact that HIV/AIDS is never considered a priority issue at the initial stages of emergencies (Aviemba, 2003 RCK Nairobi). During emergencies the pressing issues have to deal with the provision of food, shelter, basic medication and physical protection against any more attacks.
WHO policy requires the implementing agencies to identify specific risk situations within the refugee settlement which should be targeted as priorities for specific activities (for example where sexual services are bought and sold, high alcohol consumption areas and bars). However, reaching out to individuals in such places requires long periods of developed relationship with the anti-AIDS campaigners before they can listen to sex-related messages.

This is because in most African communities it is a taboo to talk about sex openly. This cultural barrier can be overcome to some extent by making such campaign efforts gender sensitive. Women, men and youths should be mobilised to reach out to their own peers.

Prevention and control is also thought to be possible through surveys of cultural beliefs, attitudes, and practices concerning sexuality, reproductive health, STDs and AIDS through formative (qualitative) research using focus groups, interviews, and if possible; KABP (Knowledge, Attitudes, Behaviour and Practices) surveys (WHO, 1994).

The challenge to this particular prevention policy is the fact that human behaviour changes with times, environment and circumstances. In fact, most communities view any challenging idea to their established norms as foreign and tools of their enemies being used to destroy their identity.

The Sudanese, Somali’s, Rwandese and Burundians who are refugees at Kakuma may not behave exactly as they would have done back in their home countries among their
own people. In fact, a survey among Rwandese refugees in Tanzania revealed that their knowledge of HIV/AIDS was quite low, lower than the average level in Kigali before the war broke out (UNHCR Survey).

This therefore means that IRC and other agencies may take quite long periods to establish some aspects of attitudes and practices among the refugee communities. On the other hand, since beliefs are more ingrained, IRC has been able to understand the reaction of the Sudanese towards condom use and the Somali’s perception of those who are HIV positive (see chapter 3).

When this kind of knowledge is established, it becomes easier to reach out to the communities through relevant and culturally sensitive strategies. The challenge to IRC is the varied number of ethnic communities and nationalities it has to cater for at the same time.

As part of assessment, WHO and UNHCR requires that INGOs like IRC liaise with local health authorities to define a management protocol for STDs (WHO/UNHCR: 1994). IRC was able to do this with NASCOP in the year 2001. IRC works in line with the national protocol but the limitation is the fact that the refugee population has not yet been included in the national strategy. This is counter-productive because there is no strong link between IRC strategies and those of the Kenya Government for Turkana District, even though IRC has catered for the locals in its programs.
Beyond assessment, there is the implementation of the program that should entail some basic elements of a response to any refugee situation. These elements are: universal precautions in health care settings, safe blood transfusion, access to condoms and access to STD care, Information, Education and Communication (IEC), and comprehensive care for people with HIV/AIDS (WHO/UNHCR 1994: 34)

Universal Precautions in Health Settings

The main elements of universal precautions are: screening of all blood for transfusion against STDs, Hepatitis B and other infectious diseases; the sterilization of all medical equipment; safe handling of sharp instruments, and safer disposal of all used items such as needles, syringes and blood bags.

Universal precautions are essential to prevent the transmission of HIV from patient to patient, health worker to patient and patient to health worker (Cronin, 1991). People working under pressure such as in refugee situations are more likely to have work-related-accidents. They may also fail to follow up sterile techniques (Cronin, 1991).

According to WHO policy, guidelines should be developed that give workers in the field information about the potential risks of their environment, how to protect themselves, and what to do in the case of accidents such as needle-stick injuries, cuts or blood spattering (WHO, 1995). This in a way prevents or lowers the chances of infection of workers because of their nature of work.
It is equally important to give clear information about what does not constitute a risk. This is appropriate because in many parts of Africa, people are still very apprehensive about issues concerning HIV/AIDS and many sometimes fail to do what is right (as in medical treatment) because of the fear of being infected. By the year 2002, the IRC medical staff were reported to have such fear (Mwanyika, 2002).

The guidelines should spell out when it is, and when it is not, appropriate to use the various items of protective clothing and why (WHO, 1995). Health workers are supposed to be given guidance on how to avoid unnecessary injections and other procedures involving sharp instruments. The guiding principle for HIV infection control is that all blood should be assumed to be potentially infectious (UNHCR/WHO 1995:34). But the risk is more prominent during the early phases of the emergency when screened blood is scarce, yet treatment has to be offered.

Even though IRC has managed to carry out the screening of all blood for HIV and Hepatitis B as an aspect of universal precaution, the high level of HIV denial among refugees hinders the observation of the other aspects of universal precautions (Mwanyika, 2002:26). Most African communities consider AIDS as a curse and do not want to identify with it in any way.

For IRC, the training has been a challenge, both because of financial constraints, low infrastructure establishment and the high turnover of staff thereby limiting the
sustenance/continuity of skill and expertise. However, it is notable that IRC has managed to install a computerized system for testing purposes.

**Access to condoms**

Generally, it has been accepted worldwide that the use of condoms is a major strategy of preventing HIV infection. Condoms offer effective protection against STDs including the sexual transmission of HIV if consistently and correctly used (WHO/GPA, 1995). According to WHO and UNHCR, condoms may be needed right from the early stages of a refugee camp. Therefore, they should be made available at no cost but once the situation has been stabilized then the issue of continuation of free distribution or institution of a form of partial cost-recovery should be considered.

However, if a charge is imposed, the refugees most of whom don’t like using them may discard the practice all the same. As already indicated earlier, some refugee communities consider condom use as a promotion of prostitution while others view it as a western intrusion meant to hinder the growth of their populations.

It is notable that condom distribution and promotion are currently carried out through the Community Health Workers (IRC staff) and NCCK. However, the supply is still irregular and documentation of distribution is incomplete (Mwanyika, 2002:26). The channels of distribution are also still limited. The major hindrance is the fact that there are strong cultural and religious barriers to condom use among some of the refugee communities (Mwanyika, 2002:26).
However, it is characteristically notable that there has been no religious intrusion on this matter on the part of the IOs. Even though JRS is a Catholic body (Catholics teach against use of condoms), it (JRS) has participated in the distribution and training on the use of condoms at Kakuma.

Safe Blood Transfusion

According to UNHCR and WHO, once the situation is such that blood transfusion within the refugees’ settlement becomes relevant then it must be ensured that the blood is safe (WHO/UNHCR, 1995:36). Blood transfusion must only be done if the facilities for safe transfusion can be organized within the refugee settlement in major operations or should be arranged with local health facilities following appropriate discussions with the Ministry of Health.

As has been illustrated earlier in the chapter, IRC has been able to screen all the blood for HIV and Hepatitis B traces. This has ensured the safety of patients who have been transfused against HIV infection. The data of the level of infection and the channels of their infection have not indicated any infection through blood transfusion. But the problem arises when there are no volunteers to offer blood. In that case, the implementers have to buy packed blood which they have to test. Sometimes they may be forced to pay blood donors. UNHCR, WHO and UNAIDS however consider that to be riskier than when the donation is voluntary.
Access to STD Care

Many health providers the world over have acknowledged that there is a high relationship between HIV/AIDS and STD infection. Because the risk of HIV transmission is greatly increased in the presence of other STDs, WHO and UNHCR advice that early establishment of STD related services becomes a priority (WHO/UNHCR 1995:36).

The prevention of STDs involves the promotion of safer sex as well as early and effective case finding and case management. However, there is a cultural preference to using traditional forms of treatment instead of exposing ones sexual practices to the medical personnel. Because of this, so many STI patients suffer quietly and fail to get full treatment.

The two organizations require that STD services should be user-friendly, private and confidential. Special arrangement may be necessary to ensure that women and young people feel comfortable using these services. But a survey among the Rwandese refugees in Tanzania revealed that the women are not allowed culturally to discuss about sex (AMREF Survey). This acted as a hindrance to the management of STIs.

In fact at Kakuma, there are many unaccompanied adolescents who live alone in groups. They don't open up easily to adults who are actually not their relatives. This also means that they may not open up easily to community health workers who are meant to monitor STI cases.
It is notable that STI management was among the first healthcare programs that were established by IRC when it started its operations at Kakuma in 1992. Although these STD services are ongoing, they are still weak (Spiegel 2002:27). This is despite the fact that there is an ongoing distribution of condoms and monitoring of the program. The weakness of the program is caused by the strict cultural codes that restrict the open discussion of sex-related issues and the accompanying secrecy concerning sex-related diseases.

Training Health Care Providers

One way of running an effective HIV/AIDS program among the refugees is the training of the health care providers. According to WHO, all health care providers, including volunteer workers should be trained in the syndromic approach to STD management (WHO/GPA: 1994). They should also receive some training in prevention, be provided with information materials and serve as channels for the distribution of condoms.

It is understandable that refugee staff are more acceptable among their communities because they are able to handle the HIV/AIDS issue in a more culturally sensitive and relevant way compared to ‘outsiders’.

But as already indicated in chapter 3 and earlier in this chapter, training has been a major challenge to INGOs because most refugee staff move away when they are resettled in other states. This does not apply only to the IRC’s HIV/AIDS program but also to all
other programs within refugee camps/setups. The other challenge has been the limitation of funds (Skye Hughes, 11th March 2003, IRC, Nairobi) for the training programs.

Also, it has been relatively difficult to organize appropriate materials in all the languages spoken by the refugees for staff who cannot speak any other language apart from their own. This brings about additional cost of consultancy and also hinders the realization of UNCHR’s and IRC’s policies of capacity building among the refugees.

Information, Education and Communication (IEC)


UNHCR and WHO also concur and illustrate that information, education and communication activities are central to a successful HIV/AIDS and STD strategy in all situations (WHO/UNHCR 1995:37). IEC includes a variety of activities at different levels, from intensive person-to-person education to mass dissemination of information.

At Kakuma, IRC has tried to create awareness about the pandemic and during the International Refugee Day celebrations (20th June 2003, University of Nairobi grounds), HIV/AIDS featured as a major theme in songs, dances and drama. One major hindrance has been the need to develop posters, leaflets and flip charts in all the local languages —
for all the nationalities and ethnic communities within the camp and also for the local Turkana community. A big challenge faces the IOs that work in camps inhabited by several refugee communities.

The challenge is the fact there is no single language that may be used on the posters to be able to reach out to all the communities. It is also difficult to establish an averagely accepted use of graphic pictures among all the communities in whole the camp. For example, the widely used pictures of lovers negotiating the use of condom is considered disrespectful in most African communities.

Comprehensive Care for People with HIV/AIDS

Comprehensive care for people with HIV-related illness is seen as a component of basic care in any refugee situation (WHO/UNHCR 1995:37). The elements of comprehensive care include clinical management, nursing care to promote and maintain hygiene and nutrition, education of individuals and families on HIV prevention and care, counseling to help individuals make informed decisions on HIV testing and social support – information and referral to support groups, welfare services and legal advice.

Most IOs and national governments accept the care of HIV-positive individuals as a major means of ensuring that the community gets to understand that HIV/AIDS is a disease like any other. It has also been realized that when HIV/AIDS patients are well taken care of, the chances of willful spread of the disease is lowered. Instead, such patients can themselves voluntarily act as anti-AIDS campaigners among their
community members. Good care also prolongs the lives of the infected. This resultantly boosts the ability of the affected family to cope up with the disease. It is for this reason that many IOs are now engaging people living with AIDS in coordinating the HIV/AIDS programs.

IRC has been able to carry out counseling in collaboration with JRS and NCCK. However, the effort to have the HIV/AIDS patients cared for at home is threatened by the fear of the disease, and stigma and discrimination among the population (International Refugee Day Celebration, 20th June, 2003, University of Nairobi grounds). Because of the fear of infection, some people fear to come in touch with the AIDS patients. Some families disown their own who are infected while some literally refuse to assist them in getting the medical attention that is required. This makes it hard for the implementing IOs to be effective in their international efforts since it is very expensive to keep such patients in hospital given that AIDS is a chronic disease which may last for many years.

**Monitoring**

IRC in its Health Care Strategy (2000:3) considers monitoring and documentation of lessons learnt to be important for future efforts. According to the World Bank (2000:33), monitoring can be used to gather information that is necessary in lowering the impact of the disease on different sectors. But IRC’s objective of using such data in initiating and running similar programs in other refugee set-ups has a very serious limitation. Each refugee camp is peculiar in location, socio-economic, cultural and religious needs. Therefore what is found out in Kakuma may not totally be relevant for another refugee
camp elsewhere. This notwithstanding, other issues such as prevention measures may be applied universally.

According to WHO and UNHCR (1995:38), data on the number of STD and HIV/AIDS cases presenting for treatment or detected in health services are essential for planning services and as an indicator of trends in STD prevalence in the community. However the two organizations advice that an under-reporting of STDs and HIV/AIDS should always be expected. Under reporting is as a result of intervening cultural factors such as the secrecy that surrounds sex-related matters and also the dynamics of mobility such as resettlement.

It is notable that monitoring and evaluation exercises are mandatory for the donor funding to continue. INGOs such as IRC carry out the monitoring exercise on a monthly basis and this has enabled it to keep track of the levels, channels and dynamics of HIV infection within the camp. However, the kind of monitoring that has been done at Kakuma has not included the impact of the disease on the different sectors in the camp.

Still there is no information on how HIV/AIDS has affected education, small-scale trade, security and households. There is only limited information of the impact on the health system within the camp whereby the facilities are becoming overstretched and staff overworked.
Mandatory HIV Testing in Refugee Situations

Another crucial policy issue is the aspect of mandatory HIV-testing of refugees. Many organizations consider this practice to be inhuman. According to UNHCR policy on HIV/AIDS, refugees should not be subjected to specific measures based on their HIV status, unless these are applied to all residents of the country concerned and are in compliance with international human rights law (UNHCR, 2002:2). UNAIDS also does not allow mandatory testing even for its own staff (UNAIDS 2002:6).

Such measures include the mandatory testing for those who are seeking asylum. At times such tests are required when refugees are being repatriated back to their home states, although this has not been reported at Kakuma Refugee Camp. In Tanzania, HIV testing is abused by religious leaders who demand that persons who plan to marry have an HIV test.

In some cases, if one of the persons is positive, the leader does not marry the couple (Spiegel 2002:13). Even among most Kenyan churches, a couple preparing for a church wedding must show documented results of their HIV-Status. In case of infection for any of the two, most of the churches do not recommend the marriage to go on.

But according to WHO, mandatory HIV-testing in refugee circumstances, with the single exception of testing blood for transfusion is not justified (WHO/UNHCR, 1995:39), and WHO has determined that such testing should not be pursued as a matter of policy. HIV testing for diagnosis of HIV related illness may be indicated, but only if two conditions
can be met: consent, counseling (pre and post) and confidentiality can be assured; a confirmatory testing procedure is undertaken as outlined in WHO's Testing Strategy.

WHO advises that people known to be HIV infected or to have AIDS should remain within their communities or within the refugee settlements, where they should have equal access to all available care and support as provided by health care facilities (WHO/UNHCR, 1995:39). The conditions set out by WHO are individual based and are not focused on Refugee Camps. Although this policy seems to defend refugees against mistreatment because of their HIV-status, it has not addressed the role and policy frameworks of the state as a major stakeholder in refugee matters.

Despite the elaborate policy framework, it is notable that mandatory testing is still practiced even at Kakuma Refugee Camp especially on those who are to be resettled in other states. This is a compulsory condition which does not consider the self will decision of the individuals refugee. IRC, UNHCR and other IOs do not have the legal capacity to force states into following the prescribed policies against mandatory testing.

What IOs have considered as an acceptable means of determining the HIV-status of refugees and all others is voluntary testing. It is against this background that IRC has built two Voluntary Counseling and Testing centres in the camp so that individuals who are desiring to know their status may be counseled and tested. WHO, UNHCR and UNAIDS, all consider this as the more ethical means of getting individuals to be tested.
Stigma and Discrimination against HIV-positive Refugees

Stigma and discrimination associated with HIV and AIDS are the greatest barriers to preventing further infections, providing care, support and treatment and alleviating impact. HIV/AIDS-related stigma and discrimination are universal, occurring in every country and region of the world (UNAIDS 2002:5).

They are triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic, the fact that AIDS is incurable, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug users (UNAIDS 2002:5). This is a major issue that IOs dealing with HIV/AIDS have to contend with. Many IOs have developed policy frameworks to address it even among the refugees.

The Declaration of Commitment, adopted by United Nations Generally Assembly Special Session on HIV/AIDS in June 2001, highlights global consensus on the importance of tackling the stigma and discrimination triggered by HIV/AIDS (UNAIDS 2002:5). The policy agreement states: “By the year 2003, nations should ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, --- and eliminate discrimination and marginalization”.

98
The UNHCR policy also illustrates that organizations involved in HIV/AIDS programs should ensure that refugees and asylum-seekers live in dignity, free from discrimination and their human rights respected (UNHCR, 2002:2). In fact the UNHCR policy on HIV/AIDS is built upon the universal principles of human rights, which advocates against all kinds of discrimination. The issue of stigma and discrimination is also related to mandatory testing and care of the HIV-positive.

However, implementing these particular policies has not been easy. The real battle against AIDS at Kakuma Refugee Camp and in the entire African continent is being played out in the families (UNAIDS 2002:9) where the authority of government and IOs rarely extends.

This sort of discrimination is intensely personal, and it takes many forms: family members neglecting their infected kins, neighbours ostracizing children orphaned by infected parents or in-laws expelling the widow of a son who has died from the disease. IRC just like any other IO has its hand tied because it cannot employ enough staff watch over the individuals who are infected or the families which are affected.

According to a report of the "Tri-Country HIV/AIDS and Refugees Workshop", for Kenya, Tanzania and Uganda held at Entebbe Uganda from 10 – 13 December 2002, protection officers in UNHCR do not necessarily see the connection between legal protection and human protection (Spiegel, 2002:2). This implies that a lot of stigma and discrimination against the HIV-positive refugees may go on for along time without being
However, no amount of protection by IOs can change the attitude of the communities towards the pandemic.

**Collaboration between Governments and International Organisations**

For any of the policies discussed above to be effective, there is need for full collaboration, coordination and cooperation among all the stakeholders especially governments and IOs.

The need for strong cooperation between the host governments and the IOs that address the issue of HIV/AIDS cannot be overemphasized. UNHCR, the leading refugee operations agency itself acknowledges the need to establish close links with UN Theme Groups and National AIDS Control Programs (NACPs) to encourage them to include refugees in their mandates (UNHCR 2002:6). UNHCR also realizes that there is need to follow the policies of NACPs in their respective countries. Where available, UNHCR uses NACP's technical resources, and where needed, assists in their technical capacity building efforts.

Even IRC has mandated itself within its policy framework to work closely with government structures and local health officials to ensure a co-ordinated and comprehensive approach to HIV control (IRC 2002:3). The policies of these two organization consider such cooperation to be necessary for the establishment and maintenance of infrastructure, sharing of technical resources, exchange and sharing of information and joining efforts in reducing stigma and discrimination.
Even governments understand the necessity for such cooperation. In its National HIV/AIDS plan, the Kenya Government strives to nurture partnerships and seek assistance from international partners to achieve the plan’s objectives. The policy expects the multilateral and bilateral development budgets to focus on the priority strategies identified in the plan (NACC 2000:16). The government also acknowledges that NGOs in Kenya (both national and international) of which IRC is one, contributes to the fight against HIV/AIDS through both prevention and care activities.

However, as much as the IOs have tried to play their role as far as the issue of collaboration with the government is concerned, the Kenya Government itself has not been very effective in implementing this policy, especially towards the refugee community (Skye Hughes, 20th June 2003, IRC, Nairobi).

Even though UNHCR’s policy aims at promoting and seeking increased access to NACPs for refugees affected by HIV/AIDS (UNHCR 2002:2), some host states such as Kenya have not yet considered the refugee population in their national strategies against HIV/AIDS (Rogo Mambo, 14th June 2003, NACC, Nairobi). In fact it is reported that some countries in Africa have not yet developed comprehensive NACP. In such cases some states are not in any way prepared to include refugees into their programs. The Ministry of Health in Kenya has not been effective in supplying HIV/STD kits and condoms to IRC as it is supposed since IRC follows the national protocol for the management of STIs. IRC also finds it hard to secure some of the equipments and drugs
that they need because of the long bureaucratic procurement policies that they have to go through (Skye Hughes, 20th June 2003, IRC, Nairobi).

IRC has also tried to build the capacity of MoH health personnel by working with the MoH to second staff to get experiences in a refugee setting. Contrarily, an interview with Mr. Mambo, the NACC Public Relations Officer revealed that IRC has not applied for funding from NACC. According to him, all the organizations that are running HIV/AIDS projects are legible for funding if they apply through the District AIDS Control Council (although there is a report that the DACC's have been bundled).

HIV/AIDS and Gender Empowerment among Refugees

It is appreciable that international policies on HIV/AIDS among refugees also consider gender issues. UNHCR policy on HIV/AIDS recognizes that women and girls should be empowered through basic rights awareness training in order to reduce their vulnerability to HIV/AIDS (UNHCR 2002.2), for example, harmful traditional practices (widow inheritance, female genital mutilation) which may contribute to the spread of the epidemic (UNHCR 1995).

But according to UNAIDS, even men, adolescents and children need special outreach programs. This is because in most refugee situations, men have lost their morale of leading their families due to the sense of worthlessness caused by the loss of property, positions and their masculine roles. They resultantly resort to alcohol, drugs and illicit sex just for psychological escape from the harsh realities. Some resort to violent activities.
against women such as rape. The adolescents also find themselves at the risk of infection because of the destruction of family units which are important for moral and sex education. Most of them are unaccompanied and live in households of peers. Due to lack of productive activities, some engage in selling and taking alcohol, commercial sex and drugs. Children on the other hand face the danger of being introduced to sexual activities too early in life. Some of them are orphaned because of HIV/AIDS.

According to the World Bank, there is supposed to be a promotion of female-controlled methods of HIV-prevention (World Bank 2000:41). In Africa, women are at higher risk of HIV infection than men and have little power in negotiating condom use. Women in particular need alternatives to condoms that they can control and that will protect them from infection of HIV and other STIs (World Bank 2000:41).

Through its policy dialogue, the Bank tries to emphasize how female-controlled prevention options, such as microbicides and female condoms, must be complemented by more concerted efforts to address the underlying gender inequalities that impact women’s risk of STIs and their ability to protect themselves with the existing range of prevention strategies (World Bank 2000:41).

However, according to Maharaj and Warwick (1996:27), any handling of gender issues related to HIV/AIDS among refugees without considering men is tantamount to failure. This is because in most households, men still dominate in decision-making and may not give into suggestions from their wives if they are not considered and included in such
awareness campaigns. Mere education and rights awareness may also not be effective if the real issues that put the refugee women at risk are not handled practically.

Global Funding of HIV/AIDS Programs

The last issue area around which policies have been developed are resources for HIV/AIDS intervention. A major factor that affects the effectiveness of HIV/AIDS programs in sub-Saharan Africa is the limitation of financial resources. The study found out that in the 2002/2003 financial year, UNHCR operated below its budget estimation because of shortage in funding. Even though UNHCR's HIV/AIDS funds are directed mainly towards refugee operations, it is notable that it draws these resources from the global scene where there are other competing needs to be funded.

According to Attaran and Sachs (2001:57), the international aid effort against AIDS is incommensurate with the severity of the epidemic. Drawing on the data that international aid donors self-reported to the Organization for Economic Cooperation and Development (OECD), it is notable that, between 1996 and 1998, finance from all rich countries to sub-Saharan Africa for projects designated as AIDS control averaged US$69 million annually, and, assuming a safe margin for under-reporting and misreporting, it is estimatable that total donor spending on HIV/AIDS control was perhaps twice that at most (Attaran and Sachs, 2001:57).

Since the late 1980s, aid levels have dropped relative to the prevalence of HIV infection and stood at about $3 per HIV-infected person. Lack of finance is now the primary
constraint on progress against AIDS, notwithstanding the belief that a lack of interest from the governments of poor countries is limiting.

The situation is even worse in the funding of HIV/AIDS programs among the refugees. Whereas states can even sign up for loans to clear off deficits for their HIV/AIDS programs, refugees are a stateless population whose only hope is the intervention of IOs.

It is argued that to produce a meaningful response to the pandemic, international assistance must be based on grants, not loans, for the developing countries. Such funding should also be directed toward projects which are proposed and designed by the affected countries themselves, and which are judged as having epidemiological merit against the pandemic by a panel of independent scientific experts (Attaran and Sachs, 2000).

If this policy guideline is followed, then the Ministry of Health is supposed to be involved in surveillance surveys of the HIV/AIDS situation at Kakuma and even help in designing the programs. This is in line with IRC's strategy which aims at following the national protocols for intervention. It also supports UNHCR's policy that strives to ensure that IOs dealing with HIV/AIDS among refugees follow the guidelines of NACP.

Such efforts should also fund concurrent needs, including prevention, drug treatment (such as high active antiretroviral therapy), and blocking mother-to-child HIV transmission (Attaran and Sachs, 2001, 57). HAART treatment has not been in operation
at Kakuma but it may be implemented next year, 2004 if IRC gets funding from the Gates Foundation.

One qualification is that all pregnant mothers get nevaripine – a drug that is used to prevent mother-to-child transmission of the HIV virus. Prevention efforts have been funded right from the time the camp was established in 1992 through awareness campaigns and the distribution of condoms. Much later with the initiation of a full-fledged HIV/AIDS programs, VCTs were also established to strengthen the prevention efforts. This effort by IRC is in line with donor-funding policies which consider prevention as a leading intervention strategy.

The understanding of the funding policies and trends of the HIV/AIDS programs cannot be complete without the analysis of the role of the governments of the affected countries. While the pandemic has been unfolding, the fight against AIDS has been substantially under-financed by governments within the heavily affected regions, and by the donor community (World Bank, 1999).

These low funding levels are, obviously, incommensurate with the severity of the AIDS pandemic. Part of the reason for the low funding which is often stressed by donor agencies has been “the reluctance of (seriously affected) governments to confront AIDS and a failure to prioritize activities in the face of severe financial and administrative constraints (Ainsworth and Teokul, 2000:356)
For this reason, for a long time in Kenya and in Africa at large, HIV/AIDS was considered just like any other health issue. It took quite long before special budgetary and financial facilities were put in place to help in the control of the pandemic. However, it is notable that this trend is changing gradually, although many African states such as Kenya do not include refugee issues in their budgets (See Chapter 3).

Another part of the problem is that many aid donors fail to base their funding policies and decisions on scientific opinion (Attaran and Sachs, 2001:57). Although many epidemiologists predicted spectacular rise in HIV infection, of 15 bilateral donor agencies surveyed by UNAIDS, less than half considered the severity of the epidemic as one of the criteria for allocating resources to AIDS control efforts (Ainsworth and Teokul, 2000:55). This lack of attention to epidemiology may explain why some donors failed to foresee the striking increase in African HIV prevalence and to increase their funding accordingly (Attaran and Sachs, 2000).

Many donor agencies are also slow to turn life-saving scientific discoveries into funded interventions on an expedited basis. Evidence has been accumulating since 1994 that antiretroviral drugs such as zidovudine or nevirapine, can reduce the frequency of mother-to-child transmission of HIV at birth by nearly 70% (Public Health Service Task Force recommendations for the use of antiretroviral drugs in pregnant women infected with HIV - 1 for maternal health and for reducing prenatal HIV-1 transmission in the United States).
The disappointment is that years later, few, if any, of the world’s major aid agencies have provided the funds to deploy this life-saving technology on a large scale. Despite nevaparine costing $4 per intervention and being available for free through corporate philanthropy, without wealthy governments offering aid to distribute the drug, only a few developing countries can implement control of mother-to-child transmission out of their own resources (Marseilli, et al, 1999: 803–808).

The disjunction between science and many donors’ funding priorities has kept this inexpensive intervention out of the hands of seriously affected poor countries for years costing many childhood lives—including refugee children.

A major funding agency to the IRC HIV/AIDS program at Kakuma is CDC—a program of the United State Agency for International Development (USAID). This means that IRC’s program may have to undergo a thorough evaluation to verify if it is complying with the “global gag” rule of the Bush administration. The Bush administration is considering extending the so-called “global gag” rule to overseas clinics that receive US funding for HIV/AIDS work (Krisberg, 2003:12) – a move that critics say will only impede efforts to fight the spread of the virus.

The gag rule, is currently used to restrict organizations that receive US family planning and population assistance funding from using their own funds to provide abortion information or legal abortion services. According to Krisberg, the possible expansion of
the rule would deny funds to international clinics that do HIV/AIDS work if those same clinics offer abortion services.

Even though IRC, a beneficiary of US funding does not offer abortion services, the application of the gag rule to clinics that conduct HIV/AIDS work will “effectively prevent the integration of family planning, maternal health and HIV/AIDS services at the community level, to the detriment of those most vulnerable to HIV and AIDS” (Centre for Health and Gender Equity). “These providers should not have a mandate handed down from our country about how they should be organizing their health services,” Kathy Hall – Martinez, JD, Director of the International Legal Program at the Centre for Reproductive Rights, told ‘The Nation’s Health’ (Krisberg 2003:1).

According to the Global AIDS Alliance many African clinics such as those ran by IRC combine HIV/AIDS, family planning and reproductive health services because doing so is cost effective and is the best way to cater to women’s needs (Krisberg, 2003). According to Hall-Martinez, an HIV-positive status or simply taking an HIV test carries a significant stigma in many countries, so separating HIV services from the rest of a clinic could undermine confidentiality.

Some critics of this policy issue signed onto a February 26 2003 letter to the president calling on President Bush not to attach the global gag rule to HIV/AIDS funds.
This chapter has attempted to assess the impact of the international policies that are being applied at Kakuma Refugee Camp in the fight against HIV/AIDS. From the analysis, several factors have been highlighted to indicate the relevance and the applicability of the stated policies. In the light of the three hypotheses, it has come out clearly that the state and the IOs must cooperate if any meaningful, effective and efficient HIV/AIDS program has to be realised.
CHAPTER FIVE

Conclusions and Recommendations

Introduction

The previous four chapters looked at different aspects of the study, ranging from the global, national to local applications of the international policies used in the fight against HIV/AIDS among refugees. This chapter offers a summary of all the findings and the conclusions. It also offers recommendations for all the stakeholders involved in combating HIV/AIDS among refugees. It illustrates the gaps that have been identified during the study and points out areas/issues that need further research.

Chapter 1 discussed relevant literature on refugees, international organizations and HIV/AIDS while laying the basic foundation, the theoretical framework of analysis for the study. It also illustrated the hypotheses that have been used to measure the findings of the study.

Chapter 2 of the study offered a historical assessment of the role of IOs in the fight against HIV/AIDS globally and in sub-Saharan Africa. It also looked at the special polices that are used to combat the pandemic among refugees. In the discussion of the role of IOs in the fight against HIV/AIDS sub-Saharan Africa, various issues came up. These issues rotated around: Global efforts against HIV/AIDS; Policies on antiretroviral drugs; HIV/AIDS control and international debt relief. The role of the UN system; The
role of the civil society; The role of faith based organizations; HIV/AIDS policies in Sub-Saharan Africa. And policies relating to HIV/AIDS among refugees.

Chapter 3 has looked into the role that is played by IRC among refugees. The particular case that the study has looked at is the Kakuma Refugee Camp. This chapter has illustrated the level and dynamics of the spread of the pandemic within the camp. It has also brought to view the aspect of collaboration – the fact that IRC is working closely with other organizations – both national and international.

It has looked into details the objectives that IRC is pursuing and the activities that it is involved in, in the attempt to prevent and control the pandemic. It has analyzed the role of the partners such as NCCK, JRS, CDC and the Kenya Government in the co-operation and coordination with IRC at Kakuma.

Chapter 4 has offered a critical analysis of the policies that IOs use in combating HIV/AIDS among refugees. It has particularly looked at the international policies regarding how HIV/AIDS can be prevented, controlled and how care should be given to those who are already infected. It has also discussed the policies that deal with partnership among the key stakeholders such as governments and IOs.

It has also discussed the issue of gender disparity and how it is related to the spread of HIV/AIDS among the refugees. Lastly, it has highlighted funding trends and examples of policies that have determined the flow of finances towards HIV/AIDS programs.
HIV/AIDS among Refugees at Kakuma

The study found out that the level of spread of HIV/AIDS at Kakuma is still as low as 5% (see chapter three) – in fact lower than the national level of 10%. The approximated rate of spread annually is only 0.4% compared to the national one of 3%. Therefore, it is deductible that IRC and its partners have significantly controlled the spread of the pandemic within the camp.

This is attributable to the integrated approach against HIV/AIDS which IRC introduced right from the beginning of the camp. Through this approach, IRC initiated the management of STIs, the distribution of condoms and the observance of universal precautions such as the screening of all blood for transfusion purposes.

On the other hand, the research found out that although the prescribed basic preventive and control measures against HIV/AIDS among refugees (see chapter four) are effective, they are usually overtaken by cultural, religious, economic, infrastructural and personnel limitation. For example it was found out that some refugee communities resist the use of condoms.

This is a major cultural challenge which can only be overcome by a continuous awareness campaign about the disease. Through such educative efforts, the understanding and attitudes of the communities within the camp will be transformed in a way that they will get to appreciate the preventive measures which the IOs have put in place.
Cultural barriers can also be gradually overcome through the training and deployment of refugee staff to reach out to their own communities. Such staff are able to use culturally relevant and sensitive strategies to address the HIV/AIDS pandemic. However, since the study established that there is a high turnover of refugee staff due to resettlement (see chapter 3), the staff should also comprise people from the local community who are permanent residents of the locality. This will ensure continuity in the handling of the HIV/AIDS program. It will also reduce the expenses incurred in the training of new staff that join the program from time to time.

The research also found out that there is a high level of poverty in the refugee camp and this was cited as a major risk factor that promotes HIV/AIDS among the refugees. To enable the refugees come out of such economic deprivation that pushes them into commercial sex, alcohol and drugs thus the risk of being infected, it is advisable that the small scale business projects within the camp should be strengthened and widened so that more individuals and households may cater for their daily needs to supplement the rations given by the IOs.

However, for this to be possible the host states such as Kenya should change their legislations which strictly restrict the refugees against moving out of the camp and not to hold jobs. The Kenya Government specifically should be committed to the proposed “Refugee Bill 2003” which has recommended the registration and employment of refugees.
As for the case of infrastructure, the study found out that the camp has only two VCTs and one major hospital. Even though these are not adequate for the over 85,000 refugees within the camp and the local population, IRC has managed to utilize them to the maximum. However, for the HIV/AIDS program to be effective, more VCTs should be established in the camp.

The local Constituency and Provincial AIDS Councils should appreciate the fact that IOs in the camp have allowed the local population to use the health facilities within the camp. They should in return also allow the refugees to use the health facilities outside the camp. However, this can only be possible if the refugee population is included and catered for in the National AIDS Strategic Plan at the national level. When this is done, the AIDS councils can then enlist the refugee AIDS programs as beneficiaries of the funding protocols.

The challenge of including the refugees in the national plan however is the overstretching of the budget allocations to AIDS programs. But this can be overcome by having a close collaboration between the government and the participating IOs in sourcing funds, policy formulation, establishment of infrastructural facilities, the sharing of personnel and in the establishment, coordination and evaluation of the HIV/AIDS programs.
Gender and HIV/AIDS among Refugees

The study found out that the level of infection is higher among refugee women and youth (adolescents). This was attributed to cases of sexual harassment such as rape during emergencies and in refugee camps and also to high levels of poverty that pushes the women and youth to be involved in commercial sex activities. It was also attributed to the breakdown of family units where moral issues and basic material provisions are catered for individuals.

For the women and youth to be salvaged from more infection, these risk factors should be addressed. The IOs should strengthen the small-scale businesses for the women and youth so that they can be engaged in meaningful and productive work. On the other hand, they should also be created for social and physical recreation activities which can occupy them during their free hours. Such recreation centres should also be used by them during their free hours. Such recreation centres should also be used as information centres for the dissemination of information on HIV/AIDS.

However, such efforts should also target men and children. If men get infected then their own spouses will. So such efforts should include reaching out to men in the homes, business areas and even in bars. Men-oriented trades such as carpentry, masonry and others should be strengthened for those who are not employed. For those who are employed within the camps, the awareness campaigns should be integrated in the work schedules. Children should also be reached in school, churches and through relevant sport activities.
HIV/AIDS – An International Problem that Needs International Response

The study found out that IOs have come into play in the combat against HIV/AIDS because the states are limited in resources (both human and financial), political will and national priority since there are so many other issues that need the attention of the policy makers. IOs play a major role in the formulation and implementation of international policies that cater for groups such as refugees. They also source for funds for the running of HIV/AIDS programs among the refugees.

However, the research found out that IOs are limited in their attempt to combat HIV/AIDS among the refugees. The first limitation is the implementation of their policies. UNHCR, the leading agency in refugee operations has formulated an HIV/AIDS policy based on the international principles of human rights (see chapter 2 and 3). This policy prescribes that the HIV-status of refugees should not be used against them in any way unless such treatment is applicable to the whole population within a state.

The study found out that this policy has not been adhered to closely at the individual, community and state levels. The major aspect in which human rights of refugees have been violated because of their HIV-status are: stigmatization and discrimination of refugees who are infected and the individuals and families affected; and the mandatory HIV testing of refugees who are seeking asylum in other states.
The research revealed that IOs are limited in protecting the infected and affected because they do not have access to homes where these individuals live. But for stigma and discrimination to be controlled, community education and awareness should be promoted. This can be done by integrating HIV/AIDS education in the school curriculum to reach out to children, youth and teachers.

Peer counseling should also be promoted among women, men and community leaders. Groups such as elders, development and business associations should also be targeted. This strategy will ensure that all people, even those who do not respond to general anti-AIDS campaigns are reached. Also, culturally relevant and sensitive graphic pictures can be used to reach out to specific communities.

As far as mandatory testing is concerned IOs such as UNHCR and IRC should establish strong advocacy campaigns targeting all the states. Through such campaigns, the IOs should clearly explain their policies and share the significances of accepting in refugees despite their HIV-status. For this kind of advocacy to be successful, the IOs should ensure regular and continuous awareness forums with the national policy makers.

The IOs should persuade the national policy makers to strengthen or integrate the implementation of the international policy requirements into their national policy frameworks. For example, the asylum states that use HIV-status to determine resettlement or not should be persuaded to review their laws so that mandatory testing is not done to reveal the HIV-status to determine resettlement.
The research also found out that IOs are limited in the area of technical personnel. It was revealed that UNHCR has only one medical officer in Kenya. This one expert is supposed to oversee all the medical programs at Kakuma and Daadab Refugee Camps. On the other hand, the attempt by IOs to build technical capacity among the refugees themselves is thwarted by the nature of mobility through resettlement (see chapter 3) and their variation in linguistic and education backgrounds.

This can be overcome by entering into an arrangement with the state to second some medical personnel to work hand in hand with the camp staff. Even though this has been done to some extent, such an arrangement should be regularized so that the availability of such personnel is consistent. The challenge on the part of the state of course is the already existing insufficiency of medical expertise in the public health system. However, the collaboration can also include training of required expertise.

Collaboration Against HIV/AIDS among Refugees

It is appreciable that HIV/AIDS is a global problem that needs a global response to be tackled effectively. However, the research found out that none of the actors - the UN system, the civil society, the faith-based organizations, the state and the individual cannot operate single-handedly. There should be strong collaboration among the IOs themselves, between the IOs and the state, and among all the stakeholders.

Individuals have a role in promoting the effectiveness of the prevention measures. It is upon the individual to adhere to the prescribed prevention and control strategies such as
abstinence, use of condoms or faithfulness to his/her spouse. The individual expert in HIV/AIDS matters can also be useful by observing the universal precautions and by acting as an agent of change against HIV/AIDS through public awareness campaigns and care of those who are already infected.

The civil society was found out to be the major implementer of the intervention policies - both national and international. The civil society is also instrumental in advocacy and the interpretation of the relevant HIV/AIDS. The challenge to this group is the political environment in which they operate – this can either promote free participation or stifle the freedom of the stakeholders.

It was also found out that some of the entities in the civil society such as NGOs do not utilize the allocated funds rightly. However, when the issue of collaboration is widened to include close co-ordination, supervision and evaluation of programs, the stakeholders will be able to prevent the squandering of funds.

The study found out that IRC has not joined any advocacy group involved in the fight against HIV/AIDS. There are many of such groups in Kenya that deal with different issues such as: the prices of drugs, stigma and discrimination, the care of those who are infected and general public campaign about the disease. The advantage of joining such organisations is the joining of effort against the pandemic. However it was found out that there is no such organisation addressing the HIV/AIDS issues among the refugees. The
IOs should therefore tie links with such advocacy groups and persuade them to consider refugee interests in their mandates.

Within the UN system, it is UNHCR, WHO and UNAIDS that were found to have participated actively in the issue of HIV/AIDS among refugees. However WHO and UNAIDS have only participated at the global scene through the formulation of policies. It is UNHCR that has formulated policies and also participated in funding and supervision of the programs.

The role of UNHCR was however found out not to be as effective as it should be. UNHCR has not played the role of advocacy actively at it has prescribed in its policy document. For example, it has not been able to convince the asylum states to stop mandatory HIV-testing.

But as indicated earlier in the chapter, the UN system should sell their policies to the state in the many international fora in which both the parties participate. Within a host state where the refugee programs are being run, UNHCR should strive to include the state in the day-to-day coordination of such programs.

In fact the study found out that the HIV/AIDS programs among the refugees cannot be fully effective without the participation of the state. The state is responsible for the tendering and procurement procedures. It was found out that in the case of Kenya such procedures are very slow and bureaucratic. This hinders IRC and the other partners from
securing the needed equipments and items at the right time when they are actually required.

The state should easen the procurement procedures but put down measures to guard against corrupt and illegal practices which may be used by individuals and organizations to abuse the provision.

There should be greater efforts by states to implement the international policies. The involvement of all the arms of government and reaching out to all the sectors should strengthen the already existing government activities. Such efforts should address the actual needs of various peoples including the refugees in regard to HIV/AIDS.

On the other hand, African states should establish homegrown policies that are relevant to the peculiar circumstances within the continent (but such policies should not contravene the international instruments which most of the states are already part of). This is because the factors that fuel the spread of HIV/AIDS in Africa and the impact of the scourge are different from the cases elsewhere.

Africa should also address HIV/AIDS among her refugee community since the refugees interact with the local populations and if joint intervention is not carried out, the efforts of both the IOs among the refugees and the state among the locals will be counterproductive.
For all the collaboration efforts to be effective, the agreements and arrangements for the sake of the same should be well documented to indicate a measure of commitment. This is because the study found out that although IRC collaborates with various organizations and the state, it has entered into a memorandum of understanding only with UNHCR. IRC should therefore strengthen its collaboration efforts with NCCK, JRS and the Kenya Government. There should be properly laid down memoranda of understanding entailing the intervention measures to be pursued by each partner. This will prevent the duplication of efforts and competition for the scarce resources.

IRC also operates within states which have their own national strategies. It should strengthen its efforts to follow the national policies and protocols. It should also expand its resource base by accessing funds from National AIDS Control Council.

**Funding for HIV/AIDS Programs among Refugees**

The study found out that global funding for HIV/AIDS programs among refugees face a lot of constraints. It was realized that funding through UNHCR is normally affected by new emergencies in different parts of the world since UNHCR is mandated to deal with both the internally displaced and the refugees. This means that when war breaks out in any part of the world, the funds are diverted to the new intervention programs. This directly affects the HIV/AIDS programs among refugees in sub-Saharan Africa.

The other limitation is the tying of funding to conditionalities. For example, it was found out that IRC may be funded in the 2004 by the Gates Foundation with a condition that
antiretroviral treatment is introduced for expectant mothers who are HIV-positive. There is also a conditionality by the US government whereby all the US funded HIV/AIDS programs have to be investigated to ensure they are not offering abortion services. As much as the two examples don’t seem negative, their application will either increase the expenses or delay the funding.

However, for the pandemic to be prevented and controlled meaningfully, the study realized that the stakeholders should collaborate in mobilizing resources both nationally and globally. The private sector, business enterprises, faith-based organizations and individuals should give more voluntarily towards the combat against HIV/AIDS among refugees. This should go along to discourage the dependence on donor funds. But when such funds are received, they should be used appropriately/ transparently, especially in the civil society. Even governments should direct such funds to the relevant ministries, departments and programs.

HIV/AIDS funding should not be pegged on conditionalities such as international debt repayment. HIV/AIDS is a global calamity claiming millions of lives, thus its prevention and control should be wholly voluntary and humanitarian. The scourge affects all states, sectors and individuals – this should compel the donor community to revise their policies on HIV/AIDS funding and divorce them from any issues such as debt repayment.

In conclusion, the study has arguably achieved all its objectives. It has critically analyzed the role played by IOs (as policy makers, financiers and implementers) in the combat
against HIV/AIDS among refugees. It has also revealed the level of impact that these IOs have in their HIV/AIDS programs among refugees and gone further to recommend possible policy changes and approaches for the strengthening of their effectiveness.

The findings realized through the objectives have been measured against the hypotheses. It has come out clearly that as much as IOs are contributing significantly by developing policies, sourcing for funds and implementing HIV/AIDS programs among refugees, their efforts are insufficient since they operate within sovereign states which themselves have their own interests and priorities. It was therefore realized that for IOs to be fully effective, the state must be willingly and voluntarily involved in the HIV/AIDS programs among the refugees.

On the other hand, it was revealed that even the state has its own limitations as far as the response against HIV/AIDS among refugees is concerned. It can only be effective if there is political will in policy formulation and implementation, the observance of international instruments, and total collaboration with the IOs that are involved in such operations.

However, it is notable that the IOs have managed to keep the spread of the pandemic among the refugees low. It was revealed that the increase in the activities of IOs have reduced the spread and the impact of HIV/AIDS among the refugees.
Issues for further Research

The main focus of this study was to analyze the role played by international organizations in the fight against HIV/AIDS among refugees. The study also undertook to examine the impact of the policies that IOs are using and has gone ahead to recommend strategies for strengthening the efforts of IOs in the attempt to combat HIV/AIDS among refugees.

The study has arguably achieved all its objectives.

However, the study was unable to establish the impact of HIV/AIDS on different sectors among refugees such as education, health, security and households. This has not been done even by earlier researchers and presents a gap which this study was not able to handle. This gap presents a future area of study. A research should be carried out on the proper procedures and methods of establishing the impact of HIV/AIDS on the above stated factors among the refugees.

The study would have been richer if it had been able to establish how the state can incorporate the refugees in the National Strategic Plan of HIV/AIDS given that the IOs themselves are limited in their intervention. This has not been done and presents a gap.

Future studies should therefore focus on the challenges of incorporating the refugees in the National Strategic Plan and how such incorporation can be effected.
REFERENCES


John and Hopkins Press.

Wolfers, I., “Programmes for Mobile Populations and the Partners”, in Lamptey P. et al.
for the Design and Management of Programmes (forthcoming).

World Bank (1999) Intensifying Action Against HIV/AIDS in Africa: Responding to a

__________ (2000) Intensifying Action against HIV/AIDS in Africa: Responding to a


of the WHO 105th Session, Agenda Item 3.3, 28th January 2000.