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Review Article

HIV and conflict in Nepal: Relation and strategy for response

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Abstract
Conflict and displacement make affected population more vulnerable to HIV infection. Refugees and internally displaced persons, in particular women and children, are at increased risk of exposure to HIV. In Nepal, there is considerable increase in the number of HIV infection since 1996 when conflict started. Along with poverty, stigma and lack of awareness, conflict related displacement, economic migration, and closure of HIV programmes have exacerbated the HIV situation in Nepal. Government has established "National AIDS Council" and launched HIV/AIDS Strategy. The strategy has not included the specific needs of displaced persons. While launching an HIV prevention programme in the conflict situation, the guidelines developed by Inter Agency Standing Committee (IASS) are important tools. This led to suggestion of an approach with implementations steps in the case of Nepal in this report.

Key words: HIV, Conflict, Nepal, Response

1. Relation between AIDS and Conflict

Durban declaration pointed out that many of the largest conflict affected population in the world were located in regions with high rates of HIV prevalence[1]. In fact, it is now well documented that conflict, displacement and poverty make affected population more vulnerable into HIV transmission[2,3,4]. However, this vulnerability does not always translate into increased rate of HIV transmission. Some situations associated with conflict such as increased isolation of communities due to destroyed infrastructure and trade; increased death rates among high risk groups; decreased casual sex associated with trauma and depression may decrease HIV transmission[5]. Thus, whether or not conflict and displacement increase HIV transmission depend upon various competing and interacting factors that may produce varied epidemiological patterns[6].

In general, there are many evidences which suggest that Refugees and Internally Displaced Persons (IDPs), in particular, women and children, are at increased risk of exposure to HIV infections with increased prevalence of HIV in conflict affected population[7, 8]. Persons who are forced to leave their home and have crossed international border are Refugees while those who have not crossed the international border but displaced within their own country are known as Internally Displaced Persons (IDPs). The main route of HIV infection in complex emergencies is sexual transmission. Sexual transmission is facilitated in a number of ways such as (i) increased sexual violence and rape by combatants (ii) increased interaction among military and civilians (iii) increased use of sex as a commodity by women and girls due to impoverishment (iv) the breakdown of family, social, and/or cultural structures and consequent loss of norms that regulate sexual activity in stable condition (v) decreased availability and utilization of reproductive health and other health services[9].

In Nepal, there is considerable increase in the number of HIV infection since 1996 when conflict started[10]. This implies a positive relationship of conflict with HIV/AIDS. There are three main ways through which conflict has contributed to the rise of HIV prevalence. Firstly, women and girls who are internally displaced to urban areas have been forced in sexual bartering for survival. Displaced women and girls end up working as cheap labourers in carpet factories, brick kilns, stone quarries and small motels. Even such low-grade jobs are hard to find and on the other hand they are offered jobs as waitress in various types of restaurants.

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Once they begin their work, they are asked to entertain male clients in different ways. Now they have no other choices for survival and no legal position to complain other than adoption of sexual exploitation. That is how the motels and cabin restaurants are running sex business in urban areas. In other words; displacement has helped sex industry to flourish and HIV to increase. Sex-workers have consistently been identified as populations with increased rates of HIV. The prevalence rate of HIV in female sex workers in Kathmandu increased from 2.7 % in 1997 to 17 % in 2000.[10] The number of Cabin restaurants in Kathmandu increased sharply since 1996. It has been estimated that there are about one hundred cabin restaurants where more than 50,000 women are working as waitresses[11]. Since most of the girls and women come from rural areas and are illiterate, they are not aware of the disease and its transmission routes. Even if they know, they can hardly negotiate safer sex with the male clients who, in most cases, are also from lower socio-economic status with similar knowledge about AIDS. Similar examples of increased sex exchange for survival have been reported from other parts of the world during conflict period. For example, in Ethiopia, the prevalence of HIV infection among Female Sex Workers (FSWs) in Addisaaba increased from 20% in 1988 to 54% in 1990 and to 73.3% in 1998 corresponding to conflict related displacement and separation of families[12]. In eastern and central Sudan 27% of single mothers had become sex workers to earn living[2].

Secondly, people get separated from their families when they, often unaccompanied by their spouses, migrate from conflicted-affected areas to non-affected areas. In Nepal, conflict has dramatically accelerated the traditional economic migration of males from rural and hills to urban centres of Nepal, India and Gulf countries. The villages were left with mainly women, children and elderly. Thousands of men and adolescents had crossed the border to India. At the end of 2002, some 8,000 people crossed the border every week[13]. Indian Embassy officials have reported that some 120,000 displaced Nepalese crossed into India during January 2003 alone[13]. A study conducted by the Save the Children Norway-Nepal (SCN-N) states that 16,871 children entered India for safety and in search of opportunities during the three-months span of July 4-October 4 in 2004[14]. This was the period when government forces carried out offensive operations on rebel hideouts in West Nepal. Though there is not official documentation of migration of Nepalese people to India, the estimate is that there is at least 1.3 to 3 million Nepalese migrant workers in different cities of India and the numbers is continuously rising[15]. There has been report that many visits sex workers in India and then bring back HIV home on their return. The disease then is known as "Mumbai Disease" in Nepal[16].

Thirdly, the conflict has affected HIV/AIDS programmes and general health services delivery. Health services are severely under-resourced and health workers are frightened to work[17]. HIV prevention and awareness work has declined in Nepal[18]. Many NGOs based in the capital city of Kathmandu are withdrawing their HIV/AIDS support programme from districts and rural areas at the time when such areas need even more help and response in emergency situation[19]. A programme had managed to reduce stigma of AIDS in one of districts of western Nepal by enlisting many volunteers. Then, most of the district has been under Maoist control. All NGO offices have been burnt down, infrastructure and government offices have been destroyed. Staff and volunteers are afraid to work and the programme's impact is under the threat[20].

2. Government Response to the situation

Nepal has established "National AIDS Council" chaired by the Prime Minister. The council with representation from government, non-government organization, private sector and civil society will take the lead in policy making and will advocate for multi-sectorial participation in the fight against HIV/AIDS. The council has endorsed the National HIV/AIDS strategy (2002-2006), which is as follows[21].

- Prevention of Sexually Transmitted Infections (STIs) and HIV infection among the vulnerable groups
- Prevention of New Infection among the young-people
- Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS
- Expansion of monitoring and evaluation frame through evidence based effective surveillance and research
- Establishment of an effective and efficient management system for an expanded response,

This strategy seems very broad and no specific approach has been targeted for displaced people especially young women and economic migrants to urban areas to help in their survival and prevent risks of HIV/AIDS infection. Authorities have tried to inhibit the running of Cabin Restaurants, take action on the managers and even to the girls. Without alternative livelihood activities or other prevention

programs, closure of restaurants or deprivation of girls to work would not solve the problem.

3. Recommended Strategy

3.1 Approach and rational

Humanitarian organizations have paid more attention to basic needs such as health, water, shelter and food and did not include HIV issues in their priority in the past. Recent studies showed that people affected by complex emergency had high vulnerability to HIV transmission and that HIV itself could be an emergency[9]. Studies also showed that links of HIV with complex situation are diverse and complex. Therefore, a multisectoral approach with national framework is needed to tackle the problem. Various international agencies have developed the guidelines to address the HIV problem in complex emergencies. Inter Agency Standing Committee (IASC) is one of them, which has produced such guidelines. The IASC is an interagency forum for co-ordination, policy development and decision making in the area of humanitarian assistance. The IASC was established in June 1992 in response to United Nations Genera Assembly Resolution on the strengthening of humanitarian assistance. The IASC is composed of various United Nation's organizations as well as non-UN humanitarian partners. The members of the IASC are the heads or their designated representatives of the UN operational agencies (UNDP, UNICEF, WFP, FAO, WHO, UNFPA, UNHCR). In addition, there is a standing invitation to International Organisation for Migration (IOM), International Committee of the Red Cross (ICRC), International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations High Commission for Human Rights (UNHCHR), the Representative of the Secretary-General in Internally Displaced Persons (IDPs), International Council of Voluntary Agencies (ICVA), Steering Committee for Humanitarian Response (SCHR) and World Bank. The IASC is chaired by the Emergency Relief Co-ordinator of the United Nations Office for the Co-ordination of Humanitarian Affairs (OCHA).The members may be reviewed each year. The IASC has a working group consisting of all the members. The working group meets every three months and can establish Task Forces to assist in developing policy or operational guidelines for relief intervention upon request of the IASC, or as required[22].

The comprehensive guidelines of IASC are to be conducted in three phases: emergency preparedness; during an emergency; and the stabilised phase[22]. An approach can be derived from these guidelines based on a country's situation and capacity assessment. Accordingly, it is relevant for organizations to adopt the following approach consisting of prevention, care and advocacy in the context of AIDS, in connection with conflict in Nepal.

Prevention

Prevention should be primary concern in addressing HIV. A variety of ways could be adopted to prevent HIV such as awareness, livelihood activities, food-aid, schooling and availability of condoms.

- Awareness program: Such programs provide understandings and knowledge of HIV and should be targeted to vulnerable groups like displaced women, waitress girls, economic migrants etc. This will motivate and help to change risky behaviour.
- Livelihood activities: Various income generating activities that will help sustain life particularly of young girls and women would prevent them adopting sexual activities for income. Vocational training such as cutting, sewing; small cottage industries such as noodles, blackboard chalk, handicrafts etc; agricultural activities such as vegetable production, poultry farming, pig-raising, fruit production could be run.
- Schooling: Displaced children mainly orphaned and separated children under the age of 18 are vulnerable to sexual violence and exploitation. One of the best ways to bring such children in their normal and daily routines is continuation on their schooling. Besides normal education, special sessions regarding HIV/AIDS run in schools would help in awareness.
- Food Aid: Ensuring food security and distributing food where necessary to displaced families and communities will lower the daily survival burden.
- Access to condoms: Condoms are considered best weapons to fight against HIV/AIDS transmission. Availability shall be ensured and correct ways of use shall be promoted.

Care

Since early HIV cases are generally asymptomatic producing a large proportion of carriers of the disease, early identification of HIV positive and strong diagnosis facility are important to break the transmission chain. Voluntary counselling and testing services will serve this purpose. Identified people having HIV/AIDS should be cared and incorporated in a centre so that such people will not be discriminated and that they will not transmit the infection to others healthy ones. Various activities can be run in centres for daily routine of infected people and to use their labour.

Advocacy

Internally Displaced Persons (IDPs) in Nepal have been neglected by the government and also unassisted by international humanitarian organizations. There is not an established national legal framework for the protection and assistance of IDPs. Organizations shall need to advocate and promote the right of IDPs especially women and children, and the disadvantaged and the oppressed groups. Stigma in Nepal is deeply rooted, which serve as a barrier to testing, counselling, treatment and care. Stigma is usually manifested as denial, shame and discrimination.

3.2 Implementation

Organizations interested to tackle the conflict related HIV problem will need a committed and complement team with local offices in the affected areas. Persons should be identified to handle and take responsibility on each of identified sectors such as advocacy, care, and prevention under the central command of the Director of the concerned Organization. Implementation shall proceed as follows:

- Conduct capacity and situation analysis of the particular area; Assess baseline data on prevalence, knowledge, attitudes and practice, and impact of HIV/AIDS, Number of female sex workers and Number of IDPs.
- Set-up monitor and evaluating plan. Develop indicators and describe tools.
- Conduct awareness campaigns in schools, IDPs camps, restaurants etc on non-discrimination, prevention and transmission of HIV/AIDS
- Prepare and develop basic behaviour Change Communication/Information Education Communication (BCC/IEC) materials
- Schooling of all displaced children with emphasis on orphans and separated children.
- Free distribution of condoms to cabin restaurants; small highway motels
- Seek food aid and other humanitarian aid from government and other donors.
- Organise discussion, demonstration etc against stigma of HIV/AIDS, discrimination of the oppressed ones, and the rights of the displaced people.
- Establish voluntary counselling and testing services and rehabilitative care for those infected with HIV.
- Set-up livelihood activities for examples open cottage industries, run vocational training, and initiate vegetable production.
- Identify partners and beneficiaries; share knowledge; raise funds; work with authorities and community people.

References

1. Durban Decleration (1990). Preventing and coping with HIV/AIDS in post-conflict societies: Gender Based Lessons from south Africa.
2. Smith A (2002). HIV/AIDS and Emergencies:analysis and recommendations for practice. Overseas Development Institute, London
3. Spiegel PB (2004). HIV/AIDS among Conflict-affected and displaced Populations: Dispelling Myths and Taking Actions. Disasters 28 (3): 322-339
4. UNAIDS (2003). HIV/AIDS AND CONFLICT .Fact Sheet http://www.unaids.org/NetTools/Misc/DocInfo.aspx?LANG=en&href=http://gva-doc-owl/WEBcontent/Documents/pub/Topics/Security/FS_Conflict_en.pdf
5. Mock et al (2004). Conflict and HIV: A framework for risk assessment to people of conflict-affected settings in Africa. Emergency themes Epidemiol. 2004;1:6
6. Gordon et al (2004). A study to Establish the Connections between HIV/AIDS and Conflict. John Snow International (UK)
7. Lawday, A. and Webb, D., 'HIV and Conflict: A Double Emergency', Save theChildren,2002 http://www.savethechildren.org.uk/temp/scuk/cache/cmsattach/212_hivconflict.pdf
8. Machel, G. (1996). Promotion and protection of the rights of children: Impact of armed conflict on children.Report of the Expert of the Secretary General of the United Nations. New York: United Nations. www.unicef.org/graca
9. Roberts, B (2004). HIV/AIDS conflict and forced migration. FMO Research guide. http://www.forcedmigration.org/guides/fmo036/fmo036.pdf
10. YOUANDAIDS (2005). Nepal at a glance: HIV Situation. http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/Nepal/index.asp#scenario
11. UN Office for the Co-ordination of Humanitarian Affairs (2005). Cabin Restaurants promote sexual exploitation. http://www.irinnews.org/report.asp?ReportID=45900&SelectRegion=Asia&SelectCountry=NEPAL
12. Holt et al (2003). Planning STI/HIV preventions among Refugees and Mobile populations: Situation Assessment of Sudanese Refugees. Disasters, 2003, 27(1):1-15
13. Reliefweb (2004). Nepal:Displaced and ignored. www.reliebweb.int/rw/rwb.nsf/
14. Kathmandu Post (05/12/04). Conflict drives children towards muglan.

15. Thieme S, Bhattrai R, Gurung G, Kollmair M, Manandha S, and Müller-Böker, U (2005). Addressing the Needs of Nepalese Migrant Workers in Nepal and in Delhi, India. Mountain Research and Development, Vol 25 No 2 May 2005: 109-114
16. Poudel KC, Jimba M, Okumura J, Joshi AB and Wakai S(2004). Migrants' risky sexual behaviours in India and at home in far western Nepal. Tropical Medicine and International Health 9:8, 897-903
17. DFID-SDC-GTZ (2003). Conflict and health in Nepal: Action for peace-bulding. District health Strengthening project; Kathmandu,Nepal
18. Singh S, Mills E, Honeyman S, Suvedi BK, Pant NP (2005).HIV in Nepal: Is the Violent Conflict Fuelling the Epidemic? PloS Med 2(8):e216
19. UN Office for the Co-ordination of Humanitarian Affairs (2005). Nepal: Focus on the plight of rural people living with HIV/AIDS.
20. http://www.irinnews.org/report.asp?ReportID=45900&SelectRegion=Asia&SelectCountry=NEPAL
21. Subramanian K. S. (2002). Impact of Conflict on HIV/AIDS in South Asia. A Background paper. http://www.sasnet.lu.se/southasiahiv.pdf
22. Country Profile (2003). The HIV/AIDS/STDs situation and the National response in Nepal. National Center for AIDS and STD Control, and UNAIDS. UN House, Kathmndu.
23. Inter Agency Standing Committee (IASC), 'Guidelines for HIV Interventions in Emergency Settings', 2003. http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf