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Citation for published version:

Wiggins, J & Palattiyil, G 2021, 'Humanitarian HIV interventions in sub-Saharan African displaced persons camps: Reviewing human rights based approaches', *International Journal of Arts, Humanities & Social Science*, vol. 2, no. 5, pp. 21-30. <<https://ijahss.net/assets/files/1620583526.pdf>>

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

Published In:

International Journal of Arts, Humanities & Social Science

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Humanitarian HIV interventions in displaced persons' camps in sub-Saharan African: A Critical Interpretive Synthesis

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Abstract

This paper analyses a twice-marginalised section of the global population: displaced persons living with HIV. A summary of non-governmental organisations' (NGO) declarations on human rights is given to provide a framework through which support in camps can be analysed. Case studies are drawn from camps in Tanzania and Kenya and show that the logistics of providing HIV services that meet human rights declarations on healthcare are difficult to implement in practice. Services should instead aim to be grass-roots based to account for the cultural, political and economic dynamics that play out in various refugee camps. The paper concludes that whilst human rights declarations are essential in outlining a respected standard for global health and dignity, experience-based learning must pave the way for better communication between humanitarian workers and NGOs so that the human rights of displaced PLWHA can be safeguarded.

Keywords: HIV; Refugee camps; Displaced persons; Sub-Saharan Africa; Human rights; Health interventions

Introduction

Negative attitudes towards refugees and asylum seekers are often validated within a nation's consciousness when opportunistic infections are detected in the displaced population. This process takes place through the ideology of 'othering', whereby diseases and undesirable characteristics are attributed as inherent characteristics of marginalised populations. The idea that undesirable traits and diseases could be found within the nation's population becomes unfathomable, and any source of detriment is deflected onto the minority population (Johnson *et al.*, 2004). Consequently, the national population ideologically and physically distances themselves from supposed subordinate populations (Germov, 2014).

The process of othering has been observed across various societies and cultures. However, in the context of displaced persons, research has shown that refugees are often migrating from politically unstable countries with a lower prevalence of HIV to stable countries with a higher prevalence of HIV (Spiegel, 2004; Silveira, 2017). Consequently, although discrimination and stigma towards displaced persons is not justified, the notion that minority populations act as reservoirs of disease is still prevalent across many societies. Medical advances in HIV management have further complicated this situation, as governments fear that the provision of treatment to displaced persons will encourage long-term settlement, thus exacerbating the emergency. Governments and host populations are therefore often reluctant to support displaced persons living with HIV, believing that responsibility should not fall upon them. Consequently, the work of NGOs and humanitarian relief actors is fundamental in safeguarding the health and well-being of people living with HIV in displaced person's camps.

Displaced persons living with HIV represent a twice marginalised section of the global population. This article critically evaluates humanitarian HIV interventions designed to reduce transmission rates and support displaced persons living with HIV in camps. Two case studies are given from sub-Saharan African refugee and internally displaced person (IDP) camps to provide an understanding of how HIV is managed in complex emergencies. We draw upon universal human rights to theoretically guide this paper. However, the ability of humanitarian organisations to implement strategies that adhere to human rights doctrines underpins case study analysis. By engaging in a critical review of humanitarian interventions, this article questions whether top-down strategies can ever be effective in supporting displaced persons living with HIV, and whether bottom-up approaches should instead be prioritised in the delivery of HIV and sexual health support strategies in camps.

Forcibly displaced people with HIV and the Right to Health

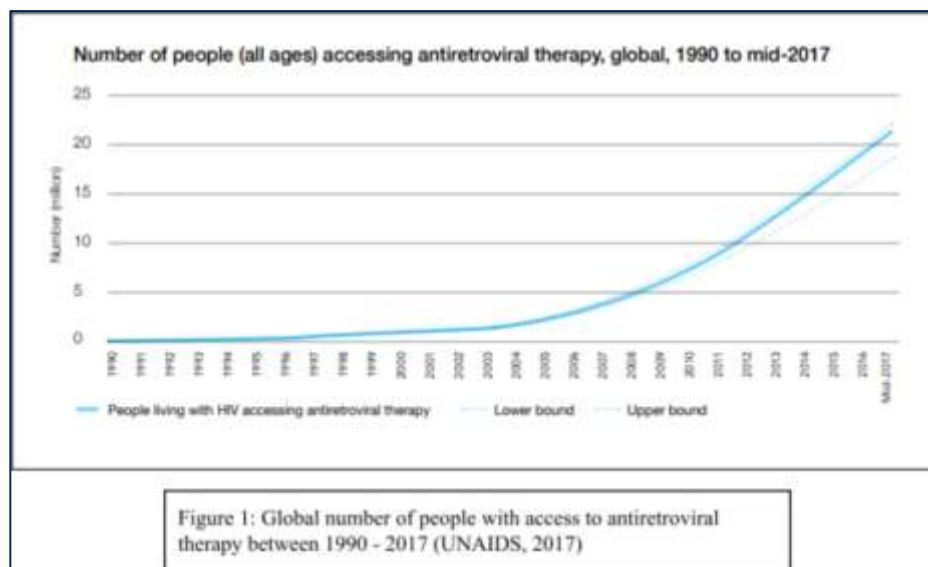
In recent years WHO has promoted Universal Health Coverage (UHC) in an effort to improve global access to healthcare services (WHO, 2019). UHC is an empirical response to WHO's 1946 universalistic, top-down declaration which states that the 'enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition' (1). WHO's approach to UHC promotes health as a holistic concept and advocates for a 'full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation and palliative care' (ibid: p.1). Included in UHC is a commitment to delivering anti-retroviral therapy (ART). These declarations and objectives remain extremely ambitious and the practice of healthcare as a universal, basic, human right is far from being achieved as illness continues to 'disproportionately affect the world's poorest populations' and approximately 50% of the global population don't have access to essential healthcare services (WHO, 2019; WHO, 2020:p.1). Furthermore, although the notion of human rights is not without criticism (see: Le, 2016), in the context of displaced persons living with HIV, they allow for an international standard to be applied for dispersed people who have been forced from their home territories.

Although the United Nations High Commissioner for Refugees (UNHCR) supports WHO's approach to healthcare, UNHCR is far more active and effective in their campaign for refugee healthcare services to be of the same standard as their host population (UNHCR, 1951; UNHCR, 2018). In 2012 approximately 50% of all countries where UNHCR operated had legislation in place that allowed displaced persons to receive the same health rights as the host populations (UNHCR, 2014). Although this still leaves a significant number of displaced persons without access to healthcare and at risk of structural violence and exploitation from host countries, working from a human rights baseline ultimately allows NGOs to establish basic care doctrines for the needs of displaced persons living with HIV.

However, NGOs are limited in how effectively they can address and support the needs of displaced persons as they are declarations and not legislation. The creation of doctrines has in no way guaranteed the safeguarding of displaced person's health. The UN advocates that the creation and design of human rights legislation must involve a wide range of actors, including marginalised and under-represented groups in order to ensure that there is a sense of communal obligation to uphold legislations, and that frameworks have the authority to hold governments accountable through three broad constituents: 'responsibility, answerability and enforceability' (UN, 2013: p.9). Any breach of human rights legislations may see individuals, groups or nation-states held accountable in international courts or through human rights commissions. Despite this, human rights violations can be difficult to enforce, an entity that Posner (2014) partially attributes to the notion that human rights are not as universal as many Western countries believe them to be. Consequently, in the context of healthcare, whilst human rights doctrines set the international standard for healthcare rights, healthcare services are only delivered based on national legislation. Therefore, a disconnect between NGO's idealistic visions and what can realistically be achieved within the confines of the nation-state is created. This disparity is inevitable, but ultimately creates a scenario where the internationally established and accepted human rights of millions of people are brought into dispute. Whilst the concept of health as a human right establishes a baseline for the implementation of healthcare across different populations, this isn't often achieved.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) broadly places basic human healthcare rights for people living with HIV into 4 categories; accessibility, availability, acceptability and quality (2017). Accessibility encompasses the right to affordable healthcare services and treatments (including antiretroviral therapy (ART), pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)), regardless of an individual's location. **Figure 1** shows that the total global number of people living with HIV who have access to ART has rapidly increased since 2004. However, UNAIDS estimates that 15.8 million people globally still do not have access to ART treatment. This means that approximately 57% of the total global HIV population do not have access to life-saving treatment. Therefore, in keeping with UNAIDS's declaration, over half the total global HIV population's human rights are currently being violated. Availability relates to 'adequate healthcare infrastructure' that is sufficiently stocked with medicines, beds and other equipment (ibid: 15). Within this section of the UNAIDS *Right to Health* mandate there is also emphasis on the availability of mental healthcare services for HIV-positive persons (2017). The section on acceptability is in keeping with WHO's (1946) declaration on healthcare as a human right as well as the UHC mandate. However, UNAIDS specifically emphasises that any discrimination based on an individual's HIV status or breach of confidentiality is a clear violation of human rights (2017). Finally, all healthcare professionals must be appropriately trained to the highest quality and all treatments and medicinal commodities must be delivered to HIV/AIDS patients at the highest standard.

Similarly, to WHO's 'right to health statement' issued in 1946, these categories are ambitious, and when thought of in the context of a chaotic refugee camp, they seem impossible to achieve. This is supported by the wider literature on the social determinants of migrant health that is generally in consensus that migrants have poorer health than native populations (Viruell-Fuentes *et al.*, 2012). Although, phenomena such as the 'healthy migrant effect' have been observed where recently arrived migrants are documented as having better general health



and well-being than native populations, this usually declines over time due to poor housing conditions, dietary changes, poverty and limited access to medical services (Fennelly, 2007). The International Organization for Migration has also recognised that ‘unsafe travel, exposure to diseases, limited access to health services, poor nutrition, psychosocial stressors, and harsh living and working conditions’ act as further detrimental determinants to migrant health (IOM, 2017: p. 14). The reality of these theories and visions will now be analysed in the context of sub-Saharan Africa’s HIV epidemiology. This will provide a context for how the virus is managed in refugee camps against the declarations designed to support displaced persons living with the virus.

Global and African HIV Epidemiology

Since the first documented case of AIDS in 1981, the longevity and pervasiveness of HIV has divided communities, created global moral panic, and brought the power of pharmaceutical companies into dispute (Lorway, 2017). Although the work of advocacy and campaign groups, the third sector and other humanitarian and UN agencies has been at the forefront of dismantling discriminatory legislation and public biases towards those living with the virus, HIV still remains one of the most stigmatised diseases in human history. WHO (2018) estimates that since the emergence of the HIV epidemic, approximately 75 million people have contracted the virus and a further 32 million have died of a HIV-related opportunistic disease. UNAIDS reported that in 2017 there were 36.9 million people living with HIV, and in the same year 940, 000 people died of a HIV-related opportunistic disease (UNAIDS, 2019). These statistics indicate that the HIV epidemic should remain on the agenda as a serious threat to global health and well-being. Sub-Saharan Africa has arguably carried the burden of the global HIV epidemic, and the continent continues to have the highest number of AIDS-related deaths worldwide (Kharsany and Karim, 2016; UNAIDS, 2017). In 2017, it was estimated that 25.7 million people were living with HIV, making Africa the most affected HIV-region in the world (WHO, 2019).

The detection of Africa’s HIV incidence was delayed in comparison to other global regions. The emergence of HIV in North America amongst men who have sex with men (MSM) led many African politicians and healthcare professionals to believe that the virus was exclusive to a specific demographic in a specific geographic region. It was not until 1983 when a number of Congolese refugees seeking asylum in Belgium tested positive for the virus that the epidemiology of HIV in Africa was fully explored (Feremans *et al.*, 1983). The contemporary prevalence of HIV in Africa has been attributed to an initial denial and ‘deliberate effort to ignore the epidemic’ by many of the continent’s national leaders (Kagaayi and Serwadda, 2016: p.191). Consequently, levels of morbidity grew across sub-Saharan Africa.

However, the prevalence of HIV in Africa cannot solely be attributed to delayed government responses. The legacy of colonial rule and decolonisation in sub-Saharan Africa has been cited as a major cause of extensive political unrest across the continent (Atti and Gulis, 2017). This has created an underdeveloped social welfare system in many countries where basic health education, clean water and treatments are not available or affordable to the majority of the general population. Consequently, a social environment has been created where the epidemic can easily spread. Theories such as the development gap and the economic notion of ‘kicking away the ladder’ are also useful in exploring why the health economics of Africa have lagged behind that of other global regions (see: Chang, 2002; Dicken, 2011). This has ultimately delayed development and weakened the frameworks through which NGOs can operate and deliver aid (Gilbert and Cunliffe, 2011). The unfinished Millennium Development Goals (MDGs) and slow progress in ‘combating HIV/AIDS, malaria and other diseases’, (UN, 2010: p.1) can be

viewed as one epistemological measure of this (Atti and Gulis, 2017). Ultimately, the high levels of morbidity that have historically been recorded across sub-Saharan Africa cannot solely be attributed to a single factor, they are instead the result of a combined network of circumstances that allowed the virus to manifest and mature.

Case studies are now drawn from sub-Saharan African refugee and IDP camps to provide an overview of how HIV is managed and treated in situations of humanitarian crisis.

African Medical and Research Foundation's (AMREF) Intervention in Tanzanian Refugee Camps

The establishment of two refugee camps in the Ngara district of Tanzania during the 1994 Rwandan genocide was a turning point in how displaced persons living with HIV were supported by NGOs and humanitarian aid organisations (Mayaud, 2001). This was the first complex emergency where HIV was considered on the aid agenda. Prior to this, there had been no effective interventions for HIV/AIDS in refugee camps (UNAIDS, 2003); reflecting on the operation, the UNHCR argued that 'never before had so large a relief operation been undertaken in an area of high HIV prevalence' (2003: p.9). Rutinwa (1996) cites that approximately 250,000 Rwandan refugees arrived in Tanzania between 28-29 April 1994, and by 'early May the population of refugees at Benaco Camp in Ngara District stood somewhere between 500,000 and 700,000' (ibid: p.295). Humanitarian workers became concerned that poor sanitary conditions and social welfare in camps would increase transmission rates, exacerbating and prolonging both the epidemic and holistic health of the camp (UNAIDS, 2003). Intervention was therefore necessary.

Interventions in the camps were implemented by AMREF and consisted of three stages: a rapid needs-assessment that included 'a literature review, a rapid STI survey, and a Knowledge, Attitudes, Behaviours and Practices Survey (KABP) on sex' (Mayaugd, 2001: p.121). This procedure allowed for primary data to be collected on attitudes towards HIV, safe sex, and sexual behaviour. Data was then reviewed and interventions such as condom supply and Information, Education and Communication (IEC) material on HIV were put in place. Local STI clinics were asked to record and monitor incidences of new HIV cases in the camps. Following this, another rapid survey was conducted to compare changes in attitudes towards safe sex and HIV, thus reviewing the effectiveness of interventions.

The results of the comparative survey found that sexual behaviour in Tanzanian refugee camps did not change and levels of transactional sex and sexual violence towards women increased, indicating that the IEC was not effective (ibid). However, following the repatriation of displaced Rwandans, a government survey found that the overall prevalence of HIV in refugees returning from Tanzania was at a lower rate in comparison to internally displaced people and those who had sought refuge in countries other than Tanzania (13.9% compared to 10.5%) (Kayirangwa *et al.*, 2006). Despite these statistics, no obvious correlation between the interventions and reduction in transmission rates was drawn.

In 1994 when the Rwandan genocide took place ART was not widely available and treatment was therefore not accessible to PLWHA inside the Tanzanian camps. However, given that sexual behaviour did not change even though free condoms were available demonstrates that the IEC provided did not have a positive impact (Gilbert and Cunliffe, 2011). The high levels of female transactional sex and sexual violence towards women recorded suggest that the IEC was not effective in targeting vulnerable women and did not prioritise female empowerment. Aside from educational resources included in the IEC, safe spaces and services for women who were victims of sexual and physical abuse should have been created in the camp. Webb (1997) argues that HIV prevention can happen by educating women on how to embody, think and act in an empowering way. She suggests that 'behavioural empowerment' which trains women to negotiate safe sex and 'structural empowerment' which advocates for the improvement of women's socio-legal status and economic independence are useful frameworks for building an IEC campaign targeted at women (ibid: 209).

At the time of the Rwandan genocide the transmission of HIV was not only difficult to control in the context of a Tanzanian refugee camp, but also on a global scale as diagnoses of HIV and AIDS-related deaths were rapidly increasing (GBD 2015 HIV Collaborators, 2016). Therefore, as this was the first time a humanitarian HIV intervention was designed and implemented in a refugee camp for displaced persons there are important lessons to take forward, which are discussed later in this article. An overview of the second case study is now given, which takes place during an era of steady progress in the understanding of HIV interventions and biomedical treatments.

Minimum Initial Service Package (MISP) in Kenyan refugee camps

Widespread violence after the 2007 Kenyan general election saw the displacement of over 500,000 national citizens (WCRWC, 2008; Adeagbo, 2011; Kamungi, 2013). IDPs sought refuge in camps across the country in both urban and rural settings, with the majority of camps and IDP population situated in the North and South Rift Regions on the country (WCRWC, 2008; UNHCR 2020). The Waki Report (2009) commissioned by the Kenyan

government into the post-election violence reported that conflict-related sexual violence was used against both women and men across the country which led to numerous new cases of HIV/AIDS. Consequently, effective HIV support services and reproductive and sexual health interventions were in high demand in numerous displaced person camps across Kenya.

The Minimum Initial Service Package (MISP) was implemented in various displaced person camps throughout the country. MISP focuses on the safeguarding of reproductive and sexual health in refugee camps. The intervention is part of a wider framework called the *Inter-Agency Field Manual* that was designed by the Inter-Agency Working Group (IAWG) and the UN to support the reproductive health of displaced persons. The IAWG and UN created the *Inter-Agency Field Manual* for humanitarian emergency situations following the Rwandan refugee crisis in Tanzania. Funded by the United Nations Population Fund (UNPF, 2015), the package contains a range of educational resources and activities designed to support maternal and child health, reduce sexual violence, support sexual violence survivors and minimise HIV transmission rates. MISP has resources to support 10,000 people for up to three months (Khaw *et al.*, 2000).

HIV interventions are recognised as a crucial component of the MISP as transmission rates increase in situations of ‘poverty, powerlessness and instability’ (UNHCR, 2006: 36). Risk factors such as unstable health infrastructure, GBV and increased transactional sex are generally seen to increase during situations of humanitarian crisis (*ibid.*). Ultimately this places HIV care and interventions firmly on the MISP agenda. Activities which help to reduce HIV transmission include: ‘ensuring safe blood transfusion practice, enforcing respect for standard precautions and making condoms freely available’ (Onyango *et al.*, 2013: 344) as well as secure, continuous access to ART drugs and menstrual products (Myers *et al.*, 2018). Many other components of MISP are also important in the reduction of HIV such as sexual violence prevention activities which encourages healthcare professionals and NGO workers to advise displaced persons who have been effected by sexual violence on where to find support services and access PEP (UNHCR, 2006). There are also activities in the maternal section of MISP on how to support pregnant, HIV-positive women, thus reducing incidences of vertical transmission. Therefore, in order to create a safe environment where the transmission of HIV can be effectively reduced and HIV-positive individuals are effectively supported, MISP theoretically advocates that a holistic, multi-faceted approach must be taken when tackling factors that increase transmission rates.

In 2008 the Women’s Commission for Refugee Women and Children visited numerous refugee camps across the country to evaluate the ‘progress the humanitarian community has made in this institutionalization of the MISP in emergency response operations’ (WCRWC, 2008: 1). When reporting on HIV interventions they found that ‘condoms were not freely available or easily accessible’ (*ibid.*: 10). Reports from the majority of camps stated that condoms were not accessible for the first four months of the unrest, and after this only male condoms were available which questioned notions of female agency and security (*ibid.*). Furthermore, MISP is meant to fully support approximately 10,000 people for up to three months. This raises questions over the location of resources as well as the UN’s commitment to MISP implementation. Reports from the camp indicated that donated blood was not screened before transfusions, thus increasing the likelihood of HIV transmissions and breaching multiple human rights (*ibid.*: UNAIDS, 2017). In another assessment of MISP implementation following the same civil violence in Kenya, Adeagbo (2011) found that implementation of MISP activities was delayed, that only a ‘small number of humanitarian workers knew of the MISP’, and that the quality of coordination was insufficient (4).

Various other studies into MISP have raised similar issues on the effectiveness of implementing MISP activities in the field, including Sudanese refugees in Chad (Onyango *et al.*, 2013). The WCRWC (2004) reported that very few humanitarian workers in Chad had any knowledge of MISP and consequently any attempts to effectively implement HIV/AIDS strategies were redundant. Condoms were not distributed within the camp and victims of sexual abuse were not advised on where they could access services, and consequently could not access PEP. Pregnant women were also not provided with clean birthing kits (*ibid.*). The WCRWC stated that ‘a lack of donor support from the UN’ and ‘delays in funding hindered timely implementation of the MISP’ (2004: 3).

MISP presents as a paradox. In theory MISP is a gender-focused, inter-disciplinary approach designed to reduce HIV transmission rates and support HIV-positive displaced persons in refugee camps, as well as safeguard other reproductive rights. The UN has produced a package for managing complex emergencies that adheres to its own human rights declaration for persons living with HIV and displaced persons. Lisam (2014) also observes that ‘disaster prone countries are expected to roll out MISP to improve humanitarian response and emergency preparedness systems’ (245). However, MISP is seldom used in refugee camps due to a lack of knowledge about its existence, objectives and goals by humanitarian agencies. In a paper entitled ‘MISP: Time for a new paradigm?’ Onyango *et al.* (2013) argue that poor logistics and coordination between NGOs has denied refugees and displaced persons living with HIV access to basic services and resources in their time of need. In their literature review of MISP case studies, they find no evidence that any MISP activity has ever been fully completed. UNHCR (2006) suggests that this may be due to a continued sentiment within humanitarian workers that reproductive health and HIV services are not a priority within emergency aid. Instead, humanitarian workers focus on short-term delivery and access to water, food, shelter and basic

medical supplies. In cases of protracted refugee situations (PRS) displaced persons remain situated in camps for more than five years. Therefore, interventions must always consider the long-term effects of emergency conflicts upon the health of displaced persons. Although supplying basic needs to displaced persons is fundamental, other human rights must not be disregarded.

Discussion: lessons learned from refugee camps in Tanzania and Kenya

Both case studies provide insight into problems specific to displaced PLWHA and transmission rates in displaced persons' camps. The interventions presented above were implemented at incredibly different time points in the HIV epidemic. Effective ART treatment did not become widely available until 1996 (Bailey and Fisher, 2008), and so in the case of the Rwandan refugee crisis in 1994, options for biomedical interventions were limited. As previously mentioned, this was also the first time that HIV found a place on the displaced persons' humanitarian agenda. Furthermore, substantial human rights doctrines were essentially absent in 1994 as UNAIDS was only founded in July 1994, two months after the establishment of refugee camps in Tanzania's Ngara district. This means that human rights doctrines on HIV/AIDS support and treatment were not available for humanitarian workers to operate through. However, by the Kenyan post-election violence in 2007, considerable strides in treatment had been made and the rights of PLWHA had firmly been safeguarded through a number of doctrines and NGO advocacies. It therefore calls for a critical examination of whether or not these medical and human rights provisions impacted the effectiveness of humanitarian HIV interventions in humanitarian settings.

In Tanzania, a localised intervention was used with AMREF administering a knowledge, attitudes, practices and behaviours survey, and then reviewing results so that interventions could be tailored to support the specific cultural needs of a targeted displaced population. A follow-up survey revealed that levels of transactional sex and sexual violence towards women increased which at first glance would suggest that the IEC was not effective. However, as the prevalence of HIV in refugees returning to Rwanda from Tanzania was lower than the rate in refugees returning from other bordering countries, perhaps a correlation between the intervention and transmission rates can be drawn. Although levels of transactional sex and sexual violence increased, the availability of condoms and reduced HIV transmission rates suggests that the IEC may have been effective in encouraging men to wear condoms in marital sex and transactional sex. Therefore, AMREF may have been successful in encouraging displaced persons to wear condoms which consequently reduced HIV rates, but the wider objective of safeguarding female health and empowerment was not achieved.

Displaced persons have an increased chance of contracting HIV in their temporary setting. Spiegel (2004) places increased risk factors into three broad categories; behavioural change, gender violence/transactional sex and reduction in resources and services (e.g. health, education, community protection)' (325). Behavioural changes are often attributed to the breakdown of traditional, social structures caused by conflicts and other complex emergencies. People often engage in risky behaviours when their traditional values and morals are challenged and dismantled. This is evident in situations of political conflict when the everyday realities of individuals are rapidly reconstructed through violence, persecution and fear. Blay-Tofey and Lee (2015) argue that this process is particularly damaging to male dominance in family structures. Displaced men often feel emasculated due to their inability to provide a secure, safe livelihood for their families. Feelings of insecurity, self-doubt and worthlessness often invite extra-marital affairs and domestic violence which increase the risk of HIV-transmission (ibid). Women may also be coerced into transactional sex by their husbands, thus, increasing transmission rates and reducing female agency and welfare.

MISP is a relatively high-profile intervention designed to support reproductive health, with a particular focus on empowering women and safeguarding the health of vulnerable individuals. As previously stated, MISP has a range of resources and educational activities available that can be used to help reduce HIV transmission rates (UNPF, 2015). Despite the human rights legislation that underpin MISP, as well as the international funds at its disposal, there is little evidence that MISP minimised HIV transmission rates in the context of the Kenyan camps, and/or supported displaced PLWHA. Furthermore, the 'golden rules' of HIV care were largely ignored with no condoms, no PEP, no screening of blood, and no clean birthing kits supplied. The inability of the UN to fully resource and support the coordination of MISP raises doubts around the capability of an international NGO to effectively deliver on-the-ground strategies that adhere to their own human rights, thus creating a fairly concerning predicament.

In one sense, AMREF's intervention in Tanzania was more successful than the MISP strategy in Kenya as resources such as condoms were available to displaced persons and HIV transmission rates were to some extent reduced. Although the bottom-up approach in Tanzania was more successful there are still areas that need improving such as information and education activities focused on female empowerment and gender-based violence. However, the top-down strategy adopted by the UN and MISP was largely unsuccessful as resources weren't delivered to camps and educational activities were not implemented. Consequently, neither intervention appears to have been overly effective in supporting PLWHA and helping control factors that increase transmission

rates such as sexual violence towards women. Ultimately, the fact that no considerable progress has been made in supporting PLWHA in displaced person camps between these two time points is a matter for critical consideration.

Human rights provide nations with an ethical standard that safeguards the morality of human beings. In times of conflict and violence, radical groups can challenge and distort moral codes through the infliction of murder, rape and torture. Human rights establish a firm line between what is right and what is wrong, which calls to international communities regardless of race, culture, and gender. Human rights are essential in outlining a global respect for dignity, freedom and health. Therefore, human rights doctrines will always be important in setting a gold standard for human behaviour, and, in this case, supporting the rights of displaced PLWHA and preventing HIV-negative persons from contracting the virus. Although NGOs who embody human rights doctrines may have been unsuccessful in implementing strategies that adhere to human rights, that is not to say that community groups and local charities would be unsuccessful in implementing strategies. The Tanzanian case study suggests that a successful IEC and an abundance of resources such as condoms can be effective in reducing HIV transmission rates in humanitarian relief efforts. With funding and support from larger NGOs such as the UN, UNHCR, and UNAIDS, successful methods can be developed and improved so that the human rights of displaced PLWHA can be safeguarded.

Moving Forward

UNAIDS (2014) is advocating for an end to the HIV/AIDS epidemic by 2030 through the implementation of a 90-90-90- strategy where 90% of people living with HIV will know their HIV status, have access to ART and consequently have a suppressed viral load. Although 90-90-90 is an ambitious declaration, if achieved it could see the beginning of the end of one of humankind's most devastating epidemics. UNAIDS and UNHCR have published a number of reports which demand leadership and political commitment, vision and action. However, from the case studies presented in this paper it is hard to imagine an immediate end to the HIV/AIDS epidemic in the context of refugee camps. Furthermore, the problem of forced displacement continues to define the 21st century with on-going humanitarian crises significantly effecting Yemen, Syria, Democratic Republic of Congo, and South Sudan whilst citizens seek humanitarian assistance in refugee camps located in Lebanon, Jordan, Turkey, and Greece.

It is argued that many NGOs are taking longer than expected to embed stronger links between legislation and the practice of human rights. A situation has been created where services are ineffectively delivered in camps and there are doubts as to whether using a rights-based approach is effective. As this paper highlights, rights-based approaches dominate the frameworks through which major stakeholders such as UNAIDS and UNHCR operate.

However, humanitarian workers struggle to adhere to human rights frameworks when in the field and have a limited awareness of the resources available to them. This disconnect sees many vulnerable, displaced persons having their human rights violated.

The need for greater cooperation between different NGOs is evident if the human rights of displaced persons living with HIV/AIDS are to be met. If progress is to be made, NGOs must review the impact of their interventions and listen to feedback from refugees and humanitarian workers in camps. A dialogue around resources must also be created so that displaced persons living with HIV can be supported medically. The stories, consequences, and effects of various HIV/AIDS strategies that have already been implemented in refugee camps should continue to be analysed, reflected upon and adapted in order to create effective, experience/evidence-based interventions. Furthermore, HIV must be cemented in the mind set of all stakeholders as a long-term development issue that needs to be addressed with immediate effect. Future approaches must be holistic, creative and interdisciplinary, but also flexible in their design to allow for the cultural, social, and economic variables found in each specific complex emergency. This will allow for greater support of refugee inhabitants and workers alike.

Human rights act as the gold standard for what can be achieved, however NGOs must engage with bottom-up approaches that consider the cultural, social, economic and gendered realities of displaced persons. The complexities of a displaced person living with HIV/AIDS must directly influence and inform human rights and interventions if development is ever to emerge from this epidemic.

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