Refugee women, girls in sub-Saharan Africa among hardest hit by HIV/AIDS crisis
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Women and girls in sub-Saharan Africa are the face of the HIV/AIDS epidemic. It's known that gender inequality renders females disproportionately more vulnerable to infection. Less publicized, however, is the plight of refugee women and girls of the sub-region. The human rights abuses they suffer during conflict and displacement put them at enormous risk for contracting HIV.

Women in sub-Saharan Africa represent a large portion of the global refugee population. The United Nations Development Fund for Women (UNIFEM) reports that women and children make up roughly 75 percent of the more than 35 million people made refugees or displaced by conflict globally. Meanwhile, five of the top ten largest refugee populations in the world originate from sub-Saharan African countries, according to UNHCR-The UN Refugee Agency.

Sub-Saharan Africa accounts for almost two-thirds of global HIV infections, with women making up 59 percent of these cases, according to the 2006 epidemic update from The Joint United Nations Programme on HIV/AIDS (UNAIDS). Young women and girls are at particular risk: the prevalence of HIV in young sub-Saharan African women ages 15 to 24 is three times higher than in their male counterparts, according to The Alliance for Microbicide Development.

Displaced women in conflict situations face a number of gender-related factors that contribute to the spread of HIV. According to UNIFEM, these include a breakdown of family, social and community structures; lack of access to health care and social services; increased sexual and gender-based violence; and increased sexual interaction between civilians and combatants. Additionally, refugees and returnees suffer stigma, discrimination and other human rights abuses that feed the cycle.

Disrupted social, economic stability

As families flee their homes and seek asylum in neighboring areas or countries, they leave behind the stable social structures of their family life, homes and communities. This includes disruption of the social norms that govern sexual behavior.

This breakdown exacerbates existing power imbalances between men and women. Even during times of peace, women lack negotiating power and equal economic status and are socialized to be submissive toward men. The result is a decrease of personal control and choice concerning when, where and with whom they have sex.

Displaced men reportedly suffer from a loss of status in their communities and families. In addition, males often are restricted in refugee camp settings, such as a denial of entrance into the local workforce. This often leads to drinking and abuse of their wives

and children, as well as unprotected sex with multiple partners. Promiscuity and abuse increases the risk of HIV transmission.

Economic destitution is pervasive. Escaping with little more than the clothes on their backs, refugee women and girls have a heightened dependence on men for physical and economic security. In most cases, women are trying to provide for themselves, their husbands and their children. In other cases, orphaned girls are fending for themselves and their siblings in what is known as child-headed households. Sexual exploitation and abuse often follows for these children.

"Survival" sex

Transactional or "survival sex" is a huge problem among this population. Women and girls are propositioned or forced to trade sex with soldiers, police, or peacekeeping forces in exchange for food, water, shelter, protection, money and other highly sought-after commodities.

"Sugar daddies" are often older men with numerous past sexual partners who expose refugee women and girls to potential abuse, pregnancy and especially HIV infection. Prevalence of HIV among military and police units can sometimes range above 50 percent, according to Human Rights Watch.

In sub-region refugee camps and elsewhere, women and girls typically undertake the burden of caring for AIDS patients and orphans. Providing hospice care makes pursuing paid work almost impossible, if not already denied by host government policies. Girls may be forced to leave school to care for a sick parent. Some girls have lost both parents to AIDS. Orphaned, poor and under-educated, they have few options for supporting themselves and their siblings.

Damaged clinics, untested blood

Civilian populations may lack access to social services, healthcare and a safe blood supply during conflict. Damage to health facilities, loss or looting of medical supplies and equipment, and difficulty reaching service locations are all challenges for displaced persons. War casualties become the primary concern, not the routine health needs of refugees.

Childbirth becomes more dangerous during humanitarian emergencies as well. Where there is no blood banking and testing system, women who hemorrhage during delivery are at risk for contracting the virus through infected blood.

Rampant gender-based violence

Gender-based violence is one of the most significant risk factors for HIV transmission to women, and sexual violence is rampant in all stages of conflict. Violent sex greatly increases a female's risk of viral contraction. The abrasions or tearing of vaginal tissue caused by forced penetration more easily enables the virus to enter the bloodstream. Adolescent girls are at even greater risk because their immature genital tracts are not yet fully developed. What's more, traditional practices like female circumcision, also known as female genital mutilation, further increase a women's HIV

vulnerability during forced and regular sex as vaginal tissues are re-broken and in some cases cut open so as to allow penetration.

Women and girls in flight are particularly vulnerable. Often alone or with children, women may be raped or forced to have sex with combatants or displaced men. Refugee settlements are supposed to protect females, but peacekeeping forces have been implicated in sexual abuse against women and children in Sierra Leone, Liberia and Democratic Republic of Congo. Some sub-region cultures falsely believe that sex with a virgin can cure HIV, and gang rapes are fueled by this myth.

Combatants will use sexual violence as a weapon of war. UNIFEM reports that women in Rwanda were deliberately infected with HIV through rape as a tool of ethnic warfare; this is also seen in Sudan's Darfur region. Rebel militias involved in the Democratic Republic of Congo civil war raped women and girls to punish the civilian population for supporting their enemy, according to Human Rights Watch. Women and girls are also targets of boys and young men who become child soldiers and are forced to become abusive as part of their training.

As previously mentioned, violence between intimate partners escalates during conflict. Violence in relationships is one of three key factors contributing to the vulnerability of the sub-region's women and girls to HIV infection, according to the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in southern Africa. The culture of silence around sexuality and exploitative sex are the other two factors.

Refugee stigma, discrimination

Refugee women and girls suffer stigma and discrimination on a number of fronts. According to UNHCR, they are often stigmatized just for being refugees by the society of their asylum due to their poverty and ethnicity. Women and girls face a third factor: discrimination based on gender.

Also, refugees are falsely accused of bringing and spreading HIV within their country of refuge. On the flipside, returnees are accused of being infected when they repatriate to their home countries.

Many societies believe widespread myths that HIV is transmitted through shaking hands, hugging, kissing, touching, playing sports, sneezing, mosquito bites or sharing bed linen. Refugees and returnees therefore face discrimination when buying food at the market, in social situations, at school, and on the sports field.

Prevention, awareness efforts

According to UNHCR, international aid organizations both large and small are conducting HIV/AIDS prevention and awareness activities in sub-region refugee and returnee settings. These include schools, antenatal care clinics, outpatient clinics, youth centers and food distribution sites.

Young refugees are trained as peer educators and encouraged to speak openly about sexual and reproductive issues and the importance of testing and counseling. Public talks, dramas, dance performances, videos, brochures, and cartoons all communicate HIV-related information. Condoms are also distributed.

Building respect for human rights

National governments, societies and individuals must recognize the fundamental human rights of refugee women and girls. Only then can they effectively combat the prevalence and impact of HIV/AIDS on this group.

A report by UNAIDS, UNIFEM and United Nations Population Fund (UNFPA) states that basic rights for women must include equal access to reproductive healthcare, treatment and drugs; reduced sexual violence and exploitation; an end to early or forced marriage; respect for a women's right to choose whether or not to bear children; legal equality within the family in property ownership, inheritance, divorce, child custody, and employment matters; support for home-based caregivers of HIV/AIDS patients and orphans; and universal education for girls.

Refugees are entitled to basic rights even when outside their own country, and host countries are obligated to enforce and protect these rights, states UNHCR. They include the right to go to school; access medical care; work in their country of asylum; and live free of torture, degrading treatment and discrimination.

Hope for the future

Gender, poverty, ethnicity and health form a complex web for refugee women and girls in the sub-region. There is hope. States, international aid agencies, and women themselves are working to fight social ills and change policies to help empower this vulnerable population.

The medical community recognizes that women lack full control of the preventative measures that can protect them from HIV, and it is currently developing topical microbicides that could reduce HIV transmission. These substances would be applied topically to female genital mucosal surfaces, putting preventative control squarely in women's hands. This technology could become available within an estimated five to ten years.

Refugee women and girls in sub-Saharan Africa have responded to HIV/AIDS with leadership, courage and determination. Their example can inspire the necessary political, economic and social changes to begin reversing this crisis.