

HIV/STI interventions in a refugee camp should begin with an unwavering commitment to the principle that it is unethical not to provide protection against disease transmission, especially in cases where the population is already known to have a high HIV prevalence, as was the case in Rwanda.



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RWANDAN REFUGEES RETURN HOME IN 1996 FROM CAMPS IN TANZANIA, THEIR TEMPORARY HOME SINCE 1994.

HIV/AIDS PREVENTION AND EDUCATION FOR REFUGEES: IMPLEMENTING EFFECTIVE EMERGENCY PROJECTS

10	INTRODUCTION
10	BACKGROUND
11	IMPLEMENTING THE PROGRAMME
13	STI/HIV-PREVENTION RESULTS
16	EMERGENCY REFUGEE HIV/AIDS INTERVENTION: 20 ESSENTIAL STEPS
19	DISCUSSION
21	LESSONS LEARNED
23	AUTHORS
23	REFERENCES

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INTRODUCTION

This case study seeks to provide a step-by-step approach to instituting an emergency HIV/AIDS intervention programme for refugees, using available best practices. The approach reflects the experience gained from the AIDS Control and Prevention (AIDSCAP) Project intervention for Rwandan refugees in the Ngara district's refugee camps in northwestern Tanzania, which ran from mid-1994 until December 1996.

The rapid onset of the Rwandan refugee crisis and its vast scope, violent ethnic origin, degree of global attention and other factors combined to form a unique situation that set this project apart from previous HIV/AIDS interventions. The project evolved over time as circumstances changed, but its flexibility and design make it replicable in most refugee situations.

The “best practices” discussed in this case study pertain to the practical considerations in mounting a quality programme—one that satisfies the needs of a refugee population—during an emergency. By their very nature, emergency situations do not afford project managers the luxury of time to design and implement programmes. Project managers need guidance in preparing for the basic elements and situations they are likely to encounter so they can take necessary steps

expeditiously, in a logical order, and to an extent appropriate to each situation.

This case study recounts the project's context, the challenges of instituting an effective HIV/AIDS intervention, and the results of the programme. It then recommends 20 specific steps for launching an emergency HIV/AIDS intervention, in the approximate order in which they should be taken, and ends by discussing sustainability, ethical considerations and lessons learned.

BACKGROUND

When civil war broke out in the spring of 1994, hundreds of thousands of Rwandans fled to neighbouring countries and over half the population became internally displaced. Refugees streamed into hastily constructed camps, and diseases—including HIV/AIDS—inevitably followed them. It is estimated that at the peak of the exodus, more than two million Rwandans were living in refugee camps neighbouring their country.

With the continuation of hostilities and no immediate sight of a resolution to the Rwandan crisis, the United States Agency for International Development (USAID) requested that Family Health International's AIDSCAP

Project support HIV/AIDS-prevention programming for the Rwandan refugee population in Tanzania. Funds were shifted from the AIDSCAP's programme in Rwanda to respond to the newly created needs of the Rwandan population in exile. AIDSCAP selected CARE International as the lead agency to manage the intervention and subcontractors John Snow International (JSI) and Population Services International (PSI) to provide additional assistance in needs assessment/evaluation and condom distribution and promotion respectively.

Four months after the exodus began, CARE launched the HIV-prevention project, staffed almost entirely by refugees. The conditions of refugee life in the Ngara camps, 18 kilometres from the Rwandan border, greatly increased the risk of exposure to HIV and other sexually transmitted infections (STIs). The demise of social structures and mores, loss of homes and jobs, overburdened health care resources, instant urbanization, overcrowding and a burgeoning commercial sex trade all led to increased risk-taking behaviour among the refugees. Women and adolescent refugees, vulnerable to violence, rape and coercive sex, were at especially high risk.

IMPLEMENTING THE PROGRAMME

When the intervention project team—consisting of the CARE project director and the PSI project manager—arrived, the project's target population in the Ngara camps was estimated at 100,000. This number grew to 165,000 in just a few months. Given the high estimates of HIV prevalence in Rwanda and the knowledge that the results of an ongoing KABP (knowledge, attitudes, beliefs and practices) survey would not be available for several months, the team

decided to begin work immediately without the benefit of accurate baseline data.

Lacking structural facilities, the team set up an office in a tent and hired a furniture maker to construct tables and benches. The project design called for the employment and training of refugees as community outreach workers, later known as AIDS Community Educators (ACEs). The ACEs were meant to cover the camp at a ratio of one educator to every 1,000 adults. PSI's condom promotion and distribution segment called for approximately 25 “promoters.”

The team posted a ‘help-wanted’ notice outside the CARE/PSI tent and at the food distribution centre—the fastest way to attract refugee workers. Anticipating a large turnout, the team was prepared to handle around 300 to 400 people with staff borrowed from the food distribution team. The next day more than 2,000 refugees showed up to apply for the positions, but the food distribution staff's experience in handling and processing large crowds eased the tension.

Identifying qualified and trustworthy staff turned into a major challenge because of the refugees' lack of income opportunities and consequent desire for employment. No matter what qualifications the posted jobs required, it seemed each applicant had them. Often the résumés were identical other than they bore different names. (It was later discovered that an enterprising teacher ran a résumé service in the camp.) Within a week the project had selected three trainers, four condom promoter supervisor/trainers, one counsellor trainer and five counsellor trainees.

The project director and project manager provided the training for the supervisors and

trainers over a two-week period. The lack of training materials and educational information in the Kinyarwanda language, however, presented several difficulties. The project hired a team of refugee artists to draw posters and illustrations for the training manuals, and a wood carver produced 150 wooden penis models for condom instruction. The trainers and supervisors assisted the project director and manager in writing the training manuals for the ACEs and promoters.

The next task was to identify candidates for the ACE and condom distribution training classes. This proved to be a tedious and lengthy process of elimination. First, résumés were reviewed, sorted and ranked. The trainers recalled the top choices and selected twice the number of applicants as positions were available. The trainers administered a brief ten-question test, and the questions eliminated those who lacked minimal knowledge of anatomy and could not identify three signs of HIV and STIs and three routes of transmission. The trainers agreed on acceptable scores for trainees. Candidates were told that those who received the highest test scores would be given the jobs. This method turned out to be acceptable to the applicants, and those who passed were eligible for the two-week training course.

The training programme was divided into three sections to keep the classes a manageable size. The ten-question test results provided useful insights into the level of knowledge about HIV and STIs. At the end of the course the trainers administered a 20-question examination to ensure the competence of all ACEs and condom promoters.

During the training period the project director prepared the refugee community for the programme by holding small meetings with the

community leaders, religious and women's leaders and other refugee outreach workers. Interestingly, all of these groups readily accepted the need for the intervention, as Rwanda's HIV/AIDS control programme had raised community awareness of HIV/AIDS prior to the refugee crisis.

After the refugee community had been informed, the project director met with each relief organization to explain the objectives and activities of the project. In the close confines of a refugee camp, good coordination and cooperation with other implementing agencies is essential for a successful outcome. More than 40 international agencies were implementing programmes in the huge Rwandan camps. Programme activities overlapped into several sectors—health, maternal/child care, community services, water and sanitation—which enabled different programmers to cross-train outreach workers.

The project also partnered with other nongovernmental organizations (NGOs) to address rape, a major problem exacerbated by the need for women and girls to leave the camps to search for firewood. The collaboration resulted in the formation of crisis intervention teams (CITs) made up of refugee volunteers trained by the NGOs to provide support for victims. CIT members acted as mediators for the victims and became the first line of response in rape cases.

Once the programme was up and running and coordination was established with other agencies, the project director and manager turned their attention to overseeing the day-to-day activities of the project. The AIDSCAP CARE team grew to 100 ACEs, 14 counsellors, one community service staff member and three trainer-supervisors. The AIDSCAP PSI team consisted of 25 promoters, one manager, one

supervisor/trainer, a sports events manager and an audiovisual technician. Handling logistics and monitoring and evaluation proved to be the most difficult tasks in the daily management of the large refugee programme staff.

Midway into the project, ACEs on home visits discovered a large number of people with AIDS symptoms who were too ill to care for themselves. This led the project to set up a home-based care service using refugee volunteers supervised by a refugee social worker to provide water and cooked food and to take patients to the hospital when needed.

The refugees sometimes took advantage of the organizations for which they worked by making unreasonable demands, such as refusing to work unless they were picked up and driven to and from their assigned territories. The project distributed bicycles to the supervisors, counsellors and promoters whose jobs required them to travel regularly among the three camps. During the rainy seasons the refugees refused to carry out their work visiting individual families unless they were provided with raincoats, umbrellas and rain boots. The project paid the staff on a scale established by the United Nations High Commissioner for Refugees (UNHCR); the rules stipulated that a refugee could hold only one job, but a number of workers were receiving salaries from several different agencies.

Keeping trained staff also proved challenging. Other agencies readily recruited workers—especially those who had already been trained. Sometimes agencies violated UNHCR rules by offering higher salaries. This practice was especially prevalent among agencies with short-term projects, and this issue dominated discussions at a number of coordination meetings. Mostly,

however, the agencies coordinated their activities well, sharing data and survey findings freely and scheduling events to avoid conflicting agendas.

Other agencies also participated in numerous AIDSCAP-sponsored sporting events and community entertainment activities at which promoters and ACEs brought their messages and materials to large crowds. The weekly soccer games and inter-camp tournaments drew crowds as large as 10,000 and involved participants from all agencies. Using enjoyable and popular activities as vehicles for promoting messages about safer sex, the project turned a sensitive topic into a familiar, if not comfortable, issue.

HIV/STI-PREVENTION RESULTS

Limitations of Data Overwhelming controversy (not to mention logistical problems) prevented the AIDSCAP Project in Ngara from taking direct measurements of HIV prevalence within the camp populations. Baseline statistics on HIV prevalence consisted of data taken from the Rwandan population before the crisis erupted in 1994. Quantitative data recorded during the project measured process indicators of project achievements. These included: knowledge, attitudes, the number of condoms and IEC (information, education and communication) materials distributed, the number of educational and counselling sessions held, and how many persons were trained. Data regarding behaviour change for preventing HIV infection relied on self-reports, as recorded by JSI in a baseline KABP survey conducted in August and September 1994. A follow-up survey was conducted almost a year later, in July 1995. Plans for a final survey in early 1997 were cancelled when the Tanzanian Army

evacuated the camps in December 1996 and forced the refugees to return to Rwanda.

Throughout the project, focus group discussions and in-depth interviews were used to provide a rich and detailed understanding of situations in the camp. Such qualitative information proved more valuable and informative than the quantitative results from the surveys. Survey data in the camps suffered from numerous problems, including: over-counting of refugees to exaggerate food and service needs; deliberate misrepresentations, sometimes owing to suspicions of the surveyors' motives or disagreement with perceived programme objectives; improper or incomplete administration of the survey instrument; and, organized interference with the conducting of the survey. The quantitative survey data, therefore, provide a less rigorous indication than their levels of statistical significance indicate, but are useful for a rough quantitative analysis.

It should be noted that the total population of the Ngara camps numbered more than 300,000 refugees. To establish baseline data for refugees under the project's management, 559 refugees (aged 15-49) were sampled from among the 165,000 refugees within the project implementation areas. After 12 months, the study team conducted a follow-up survey among the same population of 165,000 refugees. The follow-up survey carried out in June 1995 sampled 484 people using the same questionnaire and methods as in the baseline survey: this slightly smaller sample was well within acceptable statistical standards to produce a valid comparison. Teams of trained refugee surveyors solicited verbal responses during house-to-house visits. Although the population

within the project's implementation areas changed as more refugees arrived in the camps, baseline and follow-up residents remained comparable with respect to age, sex, education level and religion.

Programme Effects A comparison between baseline and follow-up surveys reveals effects that could well be attributed to the project. Knowledge of HIV/AIDS prevention was already at a high level before the intervention, which may explain why no significant changes resulted. At the time of the baseline measurement, 87 per cent of the respondents could mention at least two effective ways to prevent HIV infection. This figure changed to 85 per cent at follow-up, which was not a statistically significant difference. All categories of incorrect beliefs about HIV transmission declined, however, during the intervention period. These categories included misconceptions about contracting the disease from touching or sharing utensils with people with AIDS, using public latrines, or being bitten by mosquitoes. In addition, the proportion of respondents who were aware that healthy-looking people could carry HIV showed a statistically significant increase (from 81 to 87 per cent).

Despite the apparently high levels of knowledge and awareness, however, risky behaviour changed relatively little. No statistically significant changes were observed in the proportion of respondents answering that they had "ever used" condoms, which remained low at 37 per cent for men (from a baseline of 35 per cent) and 17 per cent for women (from a baseline of 13 per cent). Reported use of condoms during the most recent intercourse

remained at the same low level of 16 per cent for men, but increased from 5 per cent to 17 per cent for women. The condom use reported by the refugees was comparable to that reported by KABP surveys done in Rwanda prior to the refugee crisis.

The low rate of condom use cannot be explained in this case by a lack of condoms. Within a 12-month period, the project distributed 1.4 million condoms, and the surveys indicate that condom accessibility increased from 52 per cent to 95 per cent for men and from 42 per cent to 85 per cent for women, exceeding the targets set for the intervention. A total of 95 per cent of sexually active men and 85 per cent of sexually active women reported having access to condoms. The surveys revealed one alarming finding, however: attitudes towards condoms became more negative during the intervention period. Among those who did not use condoms, as many as 82 per cent did not propose the use of condoms to their partners because they felt condoms were associated with promiscuous behaviour. This figure contrasts with 29 per cent who held this attitude at the time of the baseline study.

Concurrent with findings of low condom use, the study also revealed increases in sexual activity, especially with multiple partners. More women were found to be sexually active at the time of the follow-up study (87 per cent, versus 79 per cent at baseline), and the proportion of women who had had more than one partner during the previous two months increased to 16 per cent (from 2 per cent at baseline). The proportion of men who had had more than one partner during the previous two months increased from 12 per cent to 23 per cent.

Perhaps more significantly, changes in sexual partnerships increased during the intervention period: 38 per cent of the sample reported having changed sexual partners during the course of the last year, compared to 23 per cent the year before (figures significant at the 95 per cent confidence level).

One can interpret these results in a number of ways. New patterns of dependency and distribution of wealth occurred in the refugee camps, especially during periods in which food distribution was insufficient for some groups. These patterns may have had an impact on sexual networking. In the many households headed by females, women engaged in frequent risk-taking behaviour, such as exchanging sex for food and protection. The heavy consumption of alcohol by the refugees may have contributed to short-term pairing and increased sexual activity. Moreover, a widespread propaganda campaign instigated by young Hutu men to increase the population of Hutus (even though the genocide by Hutus decreased the population of Tutsis) influenced refugee leaders to pressure men to impregnate as many women as possible. Condom use was discouraged as being counterproductive to their goal of increasing births.

Several marked differences in the demographic variables at baseline and at follow-up may provide clues to changes in sexual behaviour. Data supporting anecdotal information in this area are scant, and additional research would add to the knowledge of how all these factors influence behaviour that puts people at risk of HIV and other STIs. The net result of the intervention, therefore, can easily become confused, exaggerated or otherwise misperceived among the tangle of variables inherent in an

emergency refugee situation. Causality is beyond the means of anything short of a fully controlled study, which this refugee HIV/AIDS-intervention efforts could not provide.

EMERGENCY REFUGEE HIV/AIDS

INTERVENTION: 20 ESSENTIAL STEPS

The following 20 steps are designed to guide programme managers in planning and delivering HIV/AIDS prevention and education in the context of an emergency refugee relief project. Depending on the exigencies and circumstances particular to a given case, these steps or the order in which they occur may need to be modified. Time and circumstances permitting, many of the steps can and should be taken simultaneously, to advance with all possible speed.

1. **Review relevant literature and demographic and epidemiological data** to determine the extent of problems. The literature will help you design a preliminary strategy that will later be sharpened by first-hand knowledge gained from personal observations, focus group discussions and in-depth interviews. Understand the culture of the people you intend to help: there may be certain practices that conflict with your HIV/AIDS-intervention programme.
2. **Assess community health.** The refugee population you are dealing with is not the only population that concerns you: the local residents of the host country will be affected by the influx of refugees. Benchmarks are necessary for both refugee and local populations in order to know how your project is affecting people inside and outside the refugee camps. Assess the capacity of existing local health services and identify opportuni-

ties to tie into or coordinate with them. Also, make appropriate arrangements for local hospitals and clinics to be used as referral facilities for complicated and emergency procedures for the refugees.

3. **Inform other agencies** of your programme and enlist their cooperation and support. This step is crucial to the success of your programme. In the Ngara camps, the UNHCR medical coordinator reviewed and approved the STI treatment protocol. The UNHCR also held regular coordination meetings, during which project managers from all agencies discussed their programmes and arranged their events to avoid conflict. In a large refugee relief programme, you are likely to encounter many people from whose ideas and experiences you can benefit. The perspectives you gain from managers of other projects are vital to helping you determine what is likely to be successful (or possible) in your own project. Roads, electricity and other infrastructure and support can accommodate your project best if you let people know as early as possible what your needs are and what you plan to do.
4. **Identify refugee leaders** and influential community members, inform them of your project and enlist their help and support. The initial chaos of refugee influx into the camps may make this step difficult. Coordinate with other agencies to find out what information they have about the refugee population and meet with community leaders as soon as possible. Special efforts are needed to identify and meet with women leaders in the community.

Influential members of the refugee community can determine the success or failure of your project; stress that your organization is working in partnership with them for the health of their community.

5. **Obtain necessary supplies** (e.g., condoms, poster board for signage) and training materials from headquarters. Sometimes this will not be possible; modification of materials/supplies/methods is inevitable. It is also vital to establish appropriate storage/warehousing facilities and an inventory system for all project materials and supplies, as well as a method for regular delivery of products and services.
6. **Conduct focus group discussions and in-depth interviews** to clarify terms and deepen your understanding of important issues and social dynamics within the camp. This information will be vital when formulating an effective survey instrument and method of administering the survey. The information you get from the initial focus groups and interviews should have a definite purpose: to design the initial baseline survey to achieve meaningful results. Anticipate problems in reaching certain groups with your information and health materials. Concentrate particularly on unaccompanied minors and adolescent refugees, who are especially susceptible to HIV and often fail to receive attention in refugee relief programmes.
7. **Recruit and train refugees** to work as project surveyors and community educators. Your education efforts in the camp will need to branch out, so you should do a “training of trainers”—select trainers and translators to train a team of community educators. Conducting a baseline survey, however, should be their first project. In addition to collecting baseline data, your team should do periodic informal evaluations of the project’s effectiveness.
8. **Analyze results of baseline surveys.** When the analysis is completed, disseminate and discuss the findings with your project staff to, among other things, identify vulnerable groups, such as single women, women without husbands, adolescents and sex workers.
9. **Equip your team with the necessary materials and supplies.** Have a ready budget for emergency supplies, incentives, salaries and promotional events to begin your project. Devise a distribution system that is efficient and that concentrates not only on output but also on outcome. Handing out hundreds of thousands of condoms and leaflets—or even increasing knowledge—is not the final goal; deliberate and purposeful behaviour change is.
10. **Develop an ongoing calendar of activities** for your community educators to encourage innovative approaches to education and timely dissemination of materials and messages. Devise motivational techniques (e.g., poster contests, T-shirt and project logo design contests, painting of wall murals) for your team of educators, health workers and distributors to maintain morale and momentum in the face of inevitable (and probably mounting) challenges.
11. **Implement community activities** (soccer games, sport events, dances, inter-community competitions) to familiarize

all sectors of the refugee community with your messages in the context of enjoyable events. Associate your project with positive aspects of life in the camps, and if there are not many, create them.

12. **Establish monitoring indicators** such as an increase in distribution or demand, numbers of people seeking treatment for STIs or even prevailing attitudes in the camp regarding rape and sexual violence. Discuss with your team and with other agencies how to respond to rape, sexual violence and coercion that can put victims directly or indirectly at higher risk of HIV infection and other STIs.
13. **Set time-linked objectives** regarding your project goals as well as team members' individual performance. Make sure worker objectives are consonant with project objectives.
14. **Provide—or coordinate with agencies to provide—clinical and curative treatment** concurrently with education. Collaborate with health and sanitation workers, and cross-train workers so that they know how health, sanitation and education concerns inter-relate.
15. **Establish a home-based care programme for the terminally ill.** You may find an apparently rapid onset of AIDS cases after the programme has operated for a while. Many of those already sick with AIDS may have been too weak to flee to the refugee camps, artificially lowering the prevalence of the disease. Prepare for this eventuality as early as possible.
16. **Find and train counsellors** from the refugee community to deal with the trauma of STIs and decimation of the community from AIDS.
17. **Conduct periodic follow-up surveys** as needed to steer the project towards more effective operation based on quantitative indicators. Periodic surveys can show changes in the population over time. Always complement quantitative data with information gained from qualitative methods (focus group discussions, interviews); quantitative analysis may miss vital aspects of the situation.
18. **Continually conduct focus group discussions** to address needs and concerns within the community on issues pertaining to health. Intervention projects are dynamic, and as situations change, so do information requirements. Remember that focus groups not only help you to learn about the refugee community but also allow the refugees to think and talk about issues that affect them. Focus groups may sometimes be the only forum in which refugees can openly discuss sensitive issues in a comfortable, non-threatening atmosphere.
19. **Report findings to other agencies** and to the host government when appropriate to maintain good working relations and permit efficient collaboration. The best HIV/AIDS prevention project is a holistic one, because the disease affects nearly every aspect of life. A cooperative spirit and collaborative approach with agencies operating in other sectors of the relief effort will enhance your project.
20. **Get external evaluation** (formal 12-month reviews) to validate practices; share evaluation results with your team of workers. Positive evaluations can motivate your team, as can avoiding the prospect of a negative evaluation. Base incentives partly, but not entirely, on external evaluations.

DISCUSSION

Sustainability Are projects that are implemented in refugee camps sustainable? By definition, refugees are populations in motion, unstable and with uncertain futures. Their three main options are repatriation to their home countries, resettlement in the country of asylum, or resettlement in a third country. For many refugees, the period of limbo may span a generation or more, as in the case of Afghan refugees living in camps in Pakistan.

When “sustainability” is discussed in the context of development, it connotes a degree of ownership, a “buy in” by the governing agents or those holding authority in a community. Such a sense of ownership, however, seldom occurs in a refugee setting. Terms must be redefined for refugees. The “community” becomes the refugee camp, although some researchers reject this notion. Since refugee camps are not intended to be permanent, sustainability of HIV/STI interventions in the refugee setting is often defined in the context of individuals changing their behaviours towards safer sexual behaviour. Thus, sustainability is far from an absolute.

Social disruption, including war and internal displacement, brings dynamic change, not only in the structure of the community but also in gender roles. The so-called ‘governors’ of social behaviour, who keep people following established rules and norms, fall by the wayside in refugee camps. The disrupted social order may actually be conducive to positive behaviour change because people are more susceptible to change when they have been shocked or jolted. It may, however, have the opposite effect; sometimes only an educated guess can be made as to the outcome of such disruption.

In the case study of Benaco and Musahura Hill camps in Ngara, Tanzania, efforts were made to engage the communities’ ownership of the HIV/STI-prevention project by involving people of multiple age cohorts—adolescents, young men, young women, older adults—as well as church leaders, merchants, teachers and farmers. Over the two-year life of the AIDSCAP Ngara project, the refugees constituted a ready and “captive” audience. The sustainability of the project relied on the “captive” nature of the audience, but the sustainability of the project’s ultimate objective—behaviour change—did not. Project managers should therefore plan for and discuss with their team how the project’s objectives can continue, even after refugees leave the unnatural context of the camp or when relief agencies eventually terminate their programmes.

One such way to promote sustainability is to provide whatever materials may be necessary for the desired behaviour change, such as condoms for safer sex, or to work with the intended population to develop a variety of motivations for adopting the desired behaviour. The project also had to consider its own sustainability—its ability to continue providing condoms and other supplies for the refugees. PSI, an organization known for its social marketing of health products around the world, has contemplated instituting a phased-in social marketing of condoms as a market economy establishes itself in camps. However, in the Ngara camps, the intervention programme did not get around to social marketing condoms for a variety of reasons, including an early lack of income-earning potential among the refugees. Andreasen (1995) defines social marketing as “...the application of commercial marketing technologies to the analysis, planning, execution

and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society.”

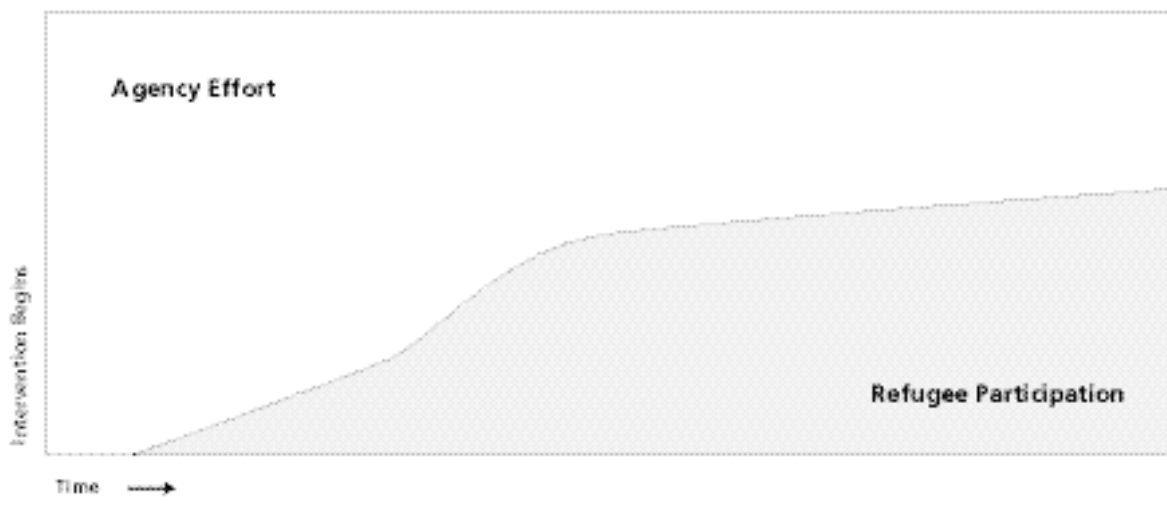
The programme for condom distribution had to rely entirely on donated materials and the continuing support of the PSI supply system, which was not sustainable in the long run. Moreover, the absence of even a nominal price for the condoms given to the refugees led to extensive waste, which arguably would not have happened if people had had to buy them. Free distribution of condoms also gave a much less accurate indication of actual condom use than marketing would have. In later months, the continuation of the condom distribution project was in perpetual jeopardy due to questionable supply and the total reliance on PSI and CARE.

Sustainability thus speaks directly to the division of responsibility and effort between

the agencies and the refugee community. How much should each contribute in order to maximize the motivation of the refugees to participate in and pursue the project’s objectives: controlling or reducing the spread of HIV/STIs through behaviour change? The answer to this question is unique to the refugee situation at hand, although the Ngara camps’ experience shows that the division of responsibility changes over time. The figure below represents graphically the experience of the Benaco and Musahara Hill camps within Ngara, in which the refugees’ participation in the project grew from essentially none at the onset to a good deal in mid-project, but then levelled off. The rectangle represents the sum of project efforts and how this was shared over time (see Sidebar 1, below).

SIDEBAR 1

Key findings of new ERA’s simulated client survey



In one aspect of the project, however, the refugees did take responsible and almost complete ownership: the sports events at which promotion and distribution of condoms took place. The project team members worked with the refugee community and created a very popular sports league that held regular soccer and volleyball games at which the health workers and condom distributors worked the crowds, handing out materials. Half-time events at the games (which drew crowds estimated at 10,000) incorporated messages about HIV/STI prevention and treatment, cleverly worked into popular skits and musical performances. The sports league clearly showed a resurgence of community pride, and the intervention project was able to associate itself with a positive aspect of camp life—one the refugees had made their own. Sustainable HIV/AIDS intervention projects need to be associated with a sense of community, hope and pride, and nothing illustrated this better than the sports league and the dances and skits held at half-time during the games.

Ethical Considerations HIV/STI intervention in a refugee camp should begin with an unwavering commitment to the principle that it is unethical not to provide protection against disease transmission, especially in cases where the population is already known to have a high HIV prevalence, as was the case in Rwanda.

Frequently during the course of the intervention, the continuation of the project—and the whole relief programme for the refugees—was in jeopardy. During these times, the decision was made not to divulge this information to the refugees. Such a lack of “open communication” does not accord with

a typical conception of partnership, which is what the intervention project tried to establish with the refugee community to encourage its participation. Openly discussing the relief programme’s tenuous status, however, may well have led to riots in the camps. This example shows just one aspect of the need to balance opposing objectives in the best interests of the community. It also shows that the locus of control lies invariably in the hands of the agencies implementing the intervention project, no matter how desirable refugee community participation may be.

Although condoms were not marketed, there were plans to institute a pricing structure to do so. Before any such steps can be taken, however, one must ensure that even the most nominal of prices would not prevent some people without incomes from purchasing a condom, which—given the assumed prevalence of HIV and STIs in the camp—could have terrible consequences.

LESSONS LEARNED

Many lessons were learned during the two-and-a-half-year Ngara project. For example, latrines were first built far from dwellings, and a number of women and girls were attacked and raped inside or on their way to the latrines. This problem demanded a structural solution, and latrines were relocated closer to dwellings. Camp management instituted a system of four-family latrines, giving the families responsibility for their maintenance. Reports of attacks subsequently declined.

Focus group discussions with male community leaders and with young men increased sensitivity to gender violence and sexual abuse, and the refugee community

began to take more responsibility for preventing such abuse. The HIV/STI intervention used focus groups extensively, not only to gather information about the refugees but also to give participants opportunities to discuss issues and gain a greater understanding of their own community.

The intervention project also found that there are limits to the goal of increasing refugee participation. At the start of the project, the implementing agencies must move the project forward as quickly as possible, which may mean postponing efforts to gain maximum refugee participation. The chaotic circumstances at the onset of a refugee crisis require an orderly, agency-driven effort for a period of time before the refugees can begin to make a meaningful contribution and start to assume “ownership” of various project activities.

Refugee participation is linked to greater programme self-sufficiency, but there may be limits to how much self-sufficiency the refugees can achieve. In the Ngara camps, the Tanzanian government’s rules initially did not allow refugees to plant vegetable gardens (because planting implies land ownership and permanency). Food, health services and supplies were all donated, and the relief programme was constantly in danger of having this vital supply line interrupted.

Programmes to create self-sufficiency of the refugee population and to institute social marketing of condoms could relieve the dependency on external donations and make projects more sustainable. Supplies of condoms might be given free at first (for ethical reasons) until a market economy forms within the camps, and this takes a surprisingly short time to happen. A programme for instituting even the most

nominal price structure might lead to equitable and more efficient distribution of condoms and other materials, with measurable results in use and with less waste. Free goods are often thrown away or squandered. Adequate supplies of condoms and other health aids must also be accompanied by appropriate behaviour change messages, especially with the support of influential leaders among the refugees.

Agencies also encountered limits to what they could accomplish. In the Ngara camps, rules required that all relief agency workers exit the camps by sundown. Efforts to use video within the camp thus had to be adjusted because the rear-projection screens CARE and PSI had received for their video project could not be used in the bright daylight. Instead, the video project had to wait until mud buildings could be constructed to provide enough darkness during the day for viewing a screen. Instead of showing a video to thousands at a time, the project had to show videos on a television screen to a small room of people. Agencies should defer to the hands-on knowledge of field staff working in trying conditions, support them with appropriate materials and respond with flexibility to changing demands.

Intervention projects must work hard at maintaining high morale among agencies and in the refugee camp in order to achieve effective results. To this end, special events, sports, drama and the use of video for education and entertainment should form a major part of any health communication strategy in refugee camps. Above all, the health intervention project should associate itself with positive aspects of camp life and be a source of pride and hope for the refugee community.

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