**HIV/ AIDS AND MEDICAL CARE ACCESSIBILITY BY REFUGEES IN BIDI-BIDI  
SETTLEMENT CAMP, NORTHWESTERN UGANDA.**

**BY**

**MARY WILLIAM KHAMIS TANDIA**

**2018/AUG/M.EH/M223424/WKD**

**A RESEARCH DISSERTATION SUBMITTED TO THE SCHOOL OF SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS**

**FOR AWARD OF THE DEGREE OF MASTERS OF SCIENCE IN ENVIRONMENT HEALTH OF NKUMBA UNIVERSITY**

**JANUARY, 2022**

**DECLARATION**I Mary William Khamis Tandia hereby declare that this research dissertation titled HIV/ AIDS and

Medical Care Accessibility by refugees in Bidi-Bidi Settlement Camp, Northwestern Uganda is my original work which to the best of my knowledge has not been submitted to any other university for the dissertation of awarding a degree. Where the work of other authors has been used, it has duly been acknowledged.

Sign…………………………………………… Date ……………………………….

**MARY WILLIAM KHAMIS TANDIA**

**APPROVAL**

This is to certify that this Research dissertation has been written by Mary William Khamis

Tandiatitled HIV/ AIDS and Medical Care Accessibility by refugees in Bidi-Bidi Settlement Camp, Northwestern Uganda under my supervision and submitted for examination with my approval.

Sign ………………………… Date………………………… **PROF. MIPH MUSOKE Ph.D (NSW) at Kensington Fogarty Fellow (Internat. Res. Biothics; Infect. Disease Epidemic) Bloomberg School of Public Health, JHU (USA) FUNAS (Medical Science)**

**SUPERVISOR**

**DEDICATION**This Research Dissertation is dedicated to my Parents, my children and lovely husband who have been encouraging me during the period of study. Their financial support, love and encouragement towards the completion of my course have been tremendous. God bless you abundantly

**ACKNOWLEDGEMENT**

I wish to thank the Almighty God for his care, blessings and grace that has enabled me to get this far.

Special thanks to my supervisor Prof. Miph Musoke for his guidance he has extended to me during my academic struggle.

I also wish to acknowledge the tremendous contributions that various institutions and individuals have rendered in order to make this academic dream a reality.

I acknowledge the Management of Nkumba University, school of science for rendering me this opportunity to pursue a Degree of Masters of science in Environment Health.

**TABLE OF CONTENT**

DECLARATION i

APPROVAL ii

DEDICATION iii

ACKNOWLEDGEMENT iv

TABLE OF CONTENT v

LIST OF TABLES ix

LIST OF FIGURES x

LIST OF ACRONYMS xi

KEY TERMS xii

ABSTRACT xiv

**CHAPTER ONE** 1

**INTRODUCTION** 1

1.1 Background 1

1.2 Problem statement 2

1.3 Main Objective 3

1.3.1 Specific Objectives 3

1.4 Research Questions 4

1.5 Justification of the Study 4

1.6. Scope of the Study 5

1.7. Significance of the Study 5

**CHAPTER TWO** 7

**LITERETURE REVIEW** 7

2.1 Introduction 7

2.1.1 Vulnerability Perspective 7

2.2 Forced Migration 13

2.3 Epidemiology of HIV/AIDS in Sub-Saharan Africa 15

2.4 Refugees, HIV/AIDS and Vulnerability 20

2.5 Policies Addressing HIV/AIDS and Refugees 22

**CHAPTER THREE** 30

**METHODOLOGY** 30

3.1 Research design and study area 30

3.2. Study population and sample size 30

3.3 Data Collection Methods and instruments 31

3.3.1 Secondary Data Sources 31

3.3.2 Primary Data sources 32

3.4 Validity and Reliability 33

3.5 Data Analysis 34

3.6. Ethical Considerations 34

**CHAPTER FOUR** 36

**DATA PRESENTATION, INTERPRETATION AND ANALYSIS** 36

4.0 Introduction 36

4.1 Respondents’ personal data 36

4.1.1. Gender 37

4.1.2. Age 38

4.1.3. Education level 38

4.1.4. Period stayed or worked in the camp 40

4.2 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp 40

4.2.1 The refugees are encouraged to take voluntary counseling and guidance services 40

4.2.2 There is diagnosis regarding the HIV/AIDS health status of the people 42

4.2.3 There are medical facilities to provide HIV/AIDS services to the people 43

4.2.4 There is regular medical support for the HIV/AIDS positive refugee patients 44

4.2.5 The medical staff and counselors creat awareness about the causes of HIV/AIDS 45

4.2.6 The counselors create awareness about the modes of transmission of HIV/AIDS 47

4.3.1 The refugees are so much engaged in unprotected sexual intercourse 48

4.3.2 The refugee children engage in sex at an early age 50

4.3.3 The refugee awareness about HIV/AIDS is still limited 51

4.3.4 Treatment for HIV/AIDS is still so limited in the area 53

4.3.5 There is no promotion of mother to child transmission 54

4.4 Policies addressing HIV/AIDS and Refugees 55

4.4.1 Integrating refugee health care into National Strategic Plans 56

4.4.2 HIV prevention activities in refugee camps should be ongoing 57

4.4.3 HIV prevention interventions should be expanded 58

4.4.4 Inter-agency Standing Committee guidelines on HIV/AIDS should be set up 60

4.4.5 Promoting refugee Self-Reliance Strategy 61

4.4.6 Implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda 63

4.4.7 Promoting Settlement Transformative Agenda 64

4.4.8 Establishing voluntary counseling and testing (VCT) programmes 65

4.4.9 Strengthening prevention of mother-to-child transmission 66

4.4.10 Promoting home based care 67

4.4.11 Support for the National AIDS Control Programme 68

**CHAPTER FIVE** 70

**SUMMARY, CONCLUSION AND RECOMMENDATIONS** 70

5.0 Introduction 70

5.1 Summary 70

5.1.1 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp 70

5.1.2 The Refugees vulnerability to HIV/AIDS in Refugee settlement camps 71

5.1.3 Policies addressing HIV/AIDS and Refugees 72

5.2 Conclusion 72

5.2.1 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp 73

5.2.2 The Refugees vulnerability to HIV/AIDS in Refugee settlement camps 73

5.2.3 Policies addressing HIV/AIDS and Refugees 74

5.3 Recommendations 74

5.4 Areas for further study 75

REFERENCES 77

APPENDICES 79

Appendix 1: Questionnaire Guide 79

Appendix 2: Interview guide 84

Appendix III. Observation checklist 86

Appendix III-Krejcie and Morgan table for sample determination 87

**LIST OF TABLES**

Table13.1: Sample size 31

Table34.1: Age 38

Table44.4: Period stayed or worked in the camp (in years) 40

Table54.5: The refugees are encouraged to take voluntary counseling and guidance services 40

Table64.6: There is diagnosis regarding the HIV/AIDS health status of the people 42

Table74.7: There are medical facilities to provide HIV/AIDS services to the people 43

Table84.8: There is regular medical support for the HIV/AIDS positive refugee patients 44

Table94.9: The medical staff and counselors create awareness among the refugees 45

Table104.10: The counselors create awareness about the modes of transmission of HIV/AIDS 47

Table114. 11. Refugees are so much engaged in unprotected sexual intercourse 48

Table124.12: Refugee children engage in sex at an early age 50

Table134.13: Refugee awareness about HIV/AIDS is still limited 52

Table144.14: Treatment for HIV/AIDS is still so limited in the area 53

Table154.15: There is no promotion of mother to child transmission 54

Table164.16: Integrating refugee health care into National Strategic Plans 56

Table174.17: HIV prevention activities in refugee camps should be ongoing 57

Table184.18: HIV prevention interventions should be expanded 59

Table194.19: The Inter-agency Standing Committee guidelines on HIV/AIDS interventions 60

Table204.20: Promoting refugee Self-Reliance Strategy 62

Table214.21: Implementing the 2006 Refugee Act and the 2010 Refugee Regulations 63

Table224.22: Promoting Settlement Transformative Agenda 64

Table234.23: Establishing voluntary counseling and testing (VCT) programmes 65

Table244.24: Strengthening prevention of mother-to-child transmission 66

Table254.25: Promoting home based care 67

Table264.26: Support for the National AIDS Control Programme 68

**LIST OF FIGURES**

Figure12.1: Vulnerability Perspective and HIV/AIDS 10

Figure24. 1: Gender 37

Figure34.2: Education level 39

**LIST OF ACRONYMS**

CDC: Centers for Disease Control and Prevention.

NAP: National AIDS Program.

CSO: Civil Society Organizations

HIV/AIDS : Human Immunodeficiency Virus Infection and Acquired Immune Deficiency

NGO: Non-Governmental Organizations

PMTCT: Prevention of Mother to Child Transmission

PrEP: Pre-exposure prophylaxis Syndrome.

UNHCR: United Nations High Commissioner for Refugees. IDPS: Internally Displaced Person

VCCT: Voluntary Confidential Counseling and Testing GLIA: Great Lakes Initiative on AIDS

WFP : World Food Program

**KEY TERMS**

**CD4+ / T helper cells:** Are white blood cells that are an essential part of the human immune system. They are often referred to as CD4 cells, T-helper cells or T4 cells. They are called helper cells because one of their main roles is to send signals to other types of immune cells, including CD8 killer cells, which then destroy the infectious particle. If CD4 cells become depleted, for example in untreated HIV infection, or following immune suppression prior to a transplant, the body is left vulnerable to a wide range of infections that it would otherwise have been able to fight.

**HIV**-**1:** is the most common type of Human Immunodeficiency Virus. It attacks your body's immune system. The virus destroys CD4 cells. These cells help your body fight infections. HIV-1 can severely damage your immune system and lead to Acquired Immune Deficiency Syndrome (AIDS).

**HIV**-**2:** One of the two types of HIV, the virus also causes AIDS. AIDS is the most advanced stage of HIV infection. HIV-2 infection is endemic to West Africa

**HIV-positive people** or **sero-positive:** are people who have the human immune deficiency virus (HIV), the agent of the currently incurable disease AIDS.

**Organization of African Unity** (OAU) was an intergovernmental organization established on 25 May 1963 in Addis Ababa, Ethiopia, with 32 signatory governments.

**Viral load:** Also known as viral burden, viral titer, is a numerical expression of the quantity of virus in a given volume. It is often expressed as viral particles, or infectious particles per mL depending on the type of assay. A higher viral burden, titer, or viral load often correlates with the severity of an active viral infection. The quantity of virus / mL can be calculated by estimating the live amount of virus in an involved body fluid.

**Pandemic:** is an epidemic of disease that has spread across a large region; for instance multiple continents, or even worldwide.

**Retrovirus:** is a type of RNA virus that inserts a copy of its genome into the DNA of a host cell that it invades, thus changing the genome of that cell.

**Immune system:** Doesa host defense system comprise many biological structures and processes within an organism that protects against disease. To function properly, an immune system must detect a wide variety of agents, known as pathogens, from viruses to parasitic worms, and distinguish them from the organism's own healthy tissue.

**Refugee:** generally speaking, is a displaced person who has been forced to cross national boundaries and who cannot return home safely. Such a person may be called an asylum seeker until granted refugee status by the contracting state or the UNHCR if they formally make a claim for asylum.

**AIDS:** is a spectrum of conditions caused by infection with the human immunodeficiency virus (HIV).

**UNAIDS:** TheJoint United Nations Programme on HIV and AIDS (UNAIDS) is the main advocate for accelerated, comprehensive and coordinated global action on the HIV/AIDS pandemic.

**World Food Programme (WFP):** is the food-assistance branch of the United Nations and the world's largest humanitarian organization addressing hunger and promoting food security.

**ART:** Standard antiretroviral therapy consists of the combination of antiretroviral (ARV) drugs t maximally suppress the **HIV** virus and stop the progression of **HIV** disease.

**Bidibidi Refugee Settlement:** is a refugee camp in northwestern Uganda. With over 270,000 South Sudanese refugees fleeing the on going civil war. As of early 2017 it was the largest refugee settlement in the world.

**Sub**-**Saharan Africa:** Is geographically, the area of the continent of Africa that lies south of the Sahara. According to the United Nations, it consists of all African countries that are fully or partially located south of the Sahara.

**ABSTRACT**

The study was about HIV/ AIDS and medical care accessibility by refugees in Bidibidi settlement camp, Northwestern Uganda and was guided by the following objectives; (a) to determine the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp, b) to assess the Refugees vulnerability to HIV/AIDS in Refugee settlement camps and c) to identify policies and health care services addressing the needs of HIV/AIDS patients in Bidibidi Refugee Settlement Camp.

The study used a cross sectional survey design with both quantitative and qualitative approaches in order to generalize the findings of the study in accordance to the objectives. Self-administered questionnaire and interviews were used to collect the data.

The study discovered that HIV / AIDS is still being transmitted among the refugees because of them still practicing unsafe sex. Also, the Ugandan government and Non-Governmental Organizations’ medical staff encourage the refugees to undergo HIV/AIDS treatment by helpin running counseling services. It was realized that education of the respondents is positively correlated with accessibility of counseling and guidance services for HIV/AIDS in Bidibid refugee camp (P=0.000). In addition, education of the respondents was found to be positively related to the awareness of the occurrence of HI V/AIDS among the refugees (P=0.000).

The study recommends that awareness of the dangers of HIV / AIDS among the refugees should be strengthened, in addition to continuous teaching of the members of the local community abou practicing safe sex in order to avoid multiple transmissions. In addition, an Inter-agency Standing Committee guideline on HIV/AIDS interventions should be set up to include Ministry of Health Uganda Aids Commission and other agencies to improve HIV/AIDS response such as VCT, prevention of mother to child transmission to the refugees.

**CHAPTER ONE: INTRODUCTION**

**1.1 Background**

The ravaging nature of the HI V/AIDS pandemic has created significant public health challenges around the world and in response, prevention efforts have focused on high-risk groups through country-specific programs. However, the increasing mobility of populations has impacted the diffusion of HIV and failing to acknowledge this relationship could undermine prevention efforts worldwide. Refugees, in particular, are a mobile population who face a variety of challenges that can inevitably increase their risk of HIV transmission (UNAIDS et al, 2005).

The relationship between HIV/AIDS and refugees is very complex as a variety of factors can influence the risk of refugees to HIV (Spiegel, 2005). Increased vulnerability results from the disruption of resources including treatment, prevention efforts and coping mechanisms. On the other hand vulnerability can also be reduced by limiting mobility and consequently decreasing exposure to the virus as well as increasing access to humanitarian services. Finally, vulnerability is influenced by prevalence gaps between populations and whether or not refugees enter into areas of higher or lower prevalence(Spiegel, 2004).Understanding this complex relationship between HI V/AIDS and refugees is imperative in order to help find ways to provide necessary health care and prevent increased transmission of HIV amongst IDP’s (Spiegel, 2004). This is particularly true in Africa, where not only the majority of HIV/AIDS cases are found, but increasing conflicts in the continent have displaced millions (UNAIDS et al., 2005).

Providing HIV/AIDS services to refugees is a daunting task due to the difficulty of establishing services in complex emergencies as well as the multitude of factors that both increase and decrease refugees’ vulnerability (Spiegel, 2004).Under international human rights law, countries of asylum

are responsible for providing equal and non-discriminatory access to existing health services (UNAIDS et al., 2005). Yet, with many countries of asylum already overburdened by the HIV/AIDS epidemic, refugees are seldom included in National AIDS programs, leaving them with limited options for HIV/AIDS services. The HIV-related needs of refugees therefore are normally addressed by humanitarian organizations within the host country.

Bidibidi in Northwestern Uganda has continually experienced an influx of refugees due to a persistent state of conflict that has engulfed South Sudan since July 2016and provides a unique case study in understanding the relationship betweenHIV/AIDS and refugees (UNMISS, 2017). UNHCR (the UN Refugee Agency) and the World Food Programme (WFP) have continually urged donors to increase support for IDP’s settlement areas. However, life-saving aid to South Sudanese refugees as to most humanitarian agencies doesn’t offer a significant shift in resource mobilization, health and social services to levels of minimum standards of care. The reason is that these settlement areas, the local health system is already weak and also lacks resources to even address the needs of the host communities (UNHCR, 2017 and WFP, 2017).This leaves refugees in Bidibidi refugee settlement camp at high risk for HIV/AIDS as they are inherently more vulnerable to the virus without adequate health resources and social stability.

**1.2 Problem statement**

There is a limited understanding of the complex relationship between HIV/AIDS and refugees around the world; the presumption is that strategic plans and approaches to incorporate when addressing the HIV-related needs of refugees seem questionable (UNAIDS, 2005). For example Bidibidi in Uganda has become one of the largest refugee camps in the world, housing over 270,000 people mostly South Sudanese refugees due to the persistent state of conflict that has engulfed South Sudan since July 2016. According to UNAIDS in 2017, South Sudanese refugees are often hosted in areas where the local health system is already weak and lacks resources to even address the needs of the host communities. This founding fact alone is supported due to treatment gaps being reported to be a major challenge in Northern Uganda where it has been estimated that only 30% of refugees in need have received treatment for HIV as of June 2017. Yet with an estimated average HIV prevalence in South Sudan refugees to be 2.7%, HIV/AIDS related deaths are recorded to be the second highest cause of mortality for IDPs due to a lack of comprehensive services. Besides, the reduction of the Global Fund allocation for HIV in South Sudan and there IDPs from $36.5 million to $29 million for the period 20 18-2020, coming at the time of adoption of HIV/AIDS Treatment for All, means that HIV response in South Sudan refugees through viral load testing, counseling services, providing antenatal care (ANC) and prevention of mother to child transmission (PMTCT) services and monitoring the treatment cascade still remain a challenge. The study therefore is aimed at studying the accessibility of medical care by HIV/AIDS patients in Bidibidi settlement camp found in Northwestern part of Uganda.

**1.3 Main Objective**

To explore and understand medical care accessibility by HIV/ AIDS patients living in Bidibidi Refugee Settlement Camp, Northwestern Uganda

**1.3.1 Specific Objectives**

The study was guided by the following specific objectives:

1. To determine the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp.
2. To assess the refugees’ vulnerability to HIV/AIDS in Refugee settlement camps.
3. To identify policies and health care services addressing the needs of HI V/AIDS patients in Bidibidi Refugee Settlement Camp.

**1.4 Research Questions**

1. What is the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp?
2. What are the major Refugee vulnerabilities to HIV/AIDS in Bidibidi Refugee settlement camp?
3. What are the major policies and health care services that are being used to address the needs of HIV/AIDS patients in Bidibidi Refugee settlement camp?

**1.5 Justification of the Study**

In neighboring countries, South Sudanese refugees are often hosted in areas where the local health system is already weak and lacks resources to even address the needs of the host communities. For instance, in Ituri and Haut Uele provinces in the DRC, HIV programming has not been fully integrated into the essential package of health services. South Sudanese refugees and the host community therefore cannot access key services such as HIV Counseling and Testing and PMTCT due to shortages of HIV testing kits at local level. Meanwhile, South Sudanese refugees on ART are difficult to trace due to conflict and insecurity, making access to refugee populations in Ituri and Haut Uele provinces difficult.

South Sudanese refugees have also sought refuge in Haut-Mbomou, in the east of the Central African Republic. Haut Mbomou has the highest HIV prevalence in CAR (11.9%) as well as inadequate health services with limited capacity to address the needs of people living with HIV.

Treatment gaps have also been reported to be a challenge in Northern Uganda where it has been estimated that only 30% of refugees in need have received treatment for HIV as of June 2017. Yet this part of the country is host to one of the biggest refugee settlement camps. Therefore, these kinds of uncertainties slightly reveal the complexity of HIV/AIDS and South Sudanese refugees.

**1.6. Scope of the Study**

This particular study intended to understand South Sudanese Refugees, HIV/ AIDS and accessibility to medical care in Bidibidi Refugee Settlement Camp, Northwestern Uganda.

The study exclusively was carried out for one month for its known that Bidibidi refugee settlement camp in Uganda has become one of the largest refugee camps in the world, housing over 270,000 people mostly South Sudanese refugees due to the persistent state of conflict that has engulfed South Sudan since July 2016. The study will use the following instruments; a camera, and interview guides, recorders, notebooks etc. other important resources to be utilized include literature review, individuals working with humanitarian bodies and donors, national authorities and other actors whose work is based in Bidibidi Refugee settlement camp, Northwestern Uganda.

**1.7. Significance of the Study**

The study shall be a step for the Inter Agency Task Team on HIV in Emergencies such that it can call on humanitarian partners and donors, national authorities and other actors for rapid action to ensure the continuation of HIV prevention, treatment and care services for those affected by the emergency both inside and outside South Sudan, as well as for refugees who have crossed the border in to neighboring countries.

Most importantly the study highlighted a range of mechanisms through which HIV/AIDS can be combated amidst any refugee crisis for example; by agitating an adequate level of funding for partners providing HIV services, both within South Sudan (including the PoC sites) and in neighboring countries. Besides whereas ensuring adequate funding is transferred to national NGOs and CSOs in Uganda and South Sudan who maintain critical links to crisis-affected communities, even during periods of intense fighting and conflict when international partners do not have access.

Lastly this study shall importantly highlight how refugees and other forcibly displaced populations can meaningfully be included in national policies, programmes, strategies, and funding proposals while continually scaling up humanitarian assistance in the most affected counties, especially in Bidibidi and other host communities, where the situation can further deteriorate rapidly if humanitarian assistance does not reach the intended beneficiaries.

**CHAPTER TWO**

**LITERETURE REVIEW**

**2.1 Introduction**

This section presents review of literature on the existing collected works about refugees and vulnerability to HIV/AIDS.

**2.2Vulnerability Perspective**

The vulnerability perspective is an important conceptual framework that seeks to understand what to hazard studies as an alternative to the “environments hazard” approach, which was prevalent in geography (19126). Since then, many authors have continued to use the vulnerability approach in the analysis of environmental and natural hazards. By analyzing the societal conditions that influence the vulnerability of individuals to hazards, the vulnerability perspective exposes underlying inequalities by looking at individual susceptibility, exposure and structural factors (Hewitt, 1997). Through this approach, risk is assessed as the combination of population vulnerability and potential hazard, leading to proposed societal solutions to address structural factors and thus decrease vulnerability (Rhodes *et al.,* 2004).

There are a number of models which geographers who study environmental risk and hazards use to analyze how various scales and structures impact vulnerability. Two hazards approach models, proposed by Wisner *at al.,* (2004) discuss how structural forces influence vulnerability and risk to natural hazards. For these models, structural factors are considered the combination of economic and social pressures from power structures, economic resources and social relations that cause unsafe conditions due to a differential access to resources (Wisner *at al.,* 2004) and for example, vulnerability to hazards can be magnified because of a lack of mitigation strategies available through public institutions, or because poverty limits the economic capacity of populations to protect themselves.

The Pressure and Release Model highlights the interaction between root cases, dynamic pressures and unsafe conditions, and how larger structural forces of political and economic systems can adversely affect the vulnerability of populations to hazards (Wisner *at al.,* 2004). Expanding on this interaction between hazard and vulnerability, Wisner at al (2004), also introduces the Access Model that focuses on the structural conditions within society that influence access to resources. Within this framework, social relations and structures of domination are analyzed in an attempt to understand the social causation of disasters. From this, scholars can analyze the progression of vulnerability of populations and how hazards are intertwined with human systems in affecting assets and livelihoods (Wisner *at al.,* 2004).

Another important concept within the vulnerability perspective is the risk environment and how particular social, cultural, economic and political conditions increase risk (Rhodes et al., 2005). At both the micro- and macro-level, the risk environment accounts for physical location, social and cultural norms, economic influences and applicable policy that combine to increase vulnerability to hazards.

Through the combination of personal decisions and structural factors, this emphasis produces a more comprehensive analysis of risk (Rhodes *et al.,* 2005). As aresult, the risk environmentis an important concept that shifts the focus of intervention from individuals tothe social situations tha place populations in vulnerable situations.

Apart from being an important tool in the study of natural hazards within geography, the vulnerability perspective has recently been adapted within the field of medical geography to become a powerful tool in explaining disease patterns. When applying the vulnerability perspective to understanding disease as an environmental hazard, the same criteria are adopted but altered to fit the mechanisms of disease and epidemic patterns. First of all, exposure relates to the exposure of an individual to the virus through direct or secondary contact. Following this vulnerability can be influenced by individual susceptibility, which is determined by pre-existing immunological or biological conditions that increase the risk of an individual for contracting the disease.

Finally, vulnerability is also assessed by looking at structural factors and specifically what societal factors influence access to health care, the ability to lead a healthy lifestyle, forces that place individuals in hazardous conditions as well as the resources they have access to.

Within the study of HIV/AIDS and medical geography, the vulnerability perspective has been adopted to analyze the spatial distribution of HIV prevalence. While scholars have acknowledged that populations have similar individual susceptibility to HIV, structural factors play a large par in determining exposure to the virus. Looking at economic, social and cultural factors contributes to differential access to resources, which in turn creates different levels of vulnerability to HIV transmission depending on an individual or group access to these resources. With this approach, risk is no longer based on purely biologica characteristics but rather, is expanded to include the influences of social, cultural and economic factors (Mayer, 2005). Therefore, the vulnerability perspective emphasizes how HIV diffusion patterns commonly reflect the spatial distribution of vulnerable groups by isolating them both geographically and socially (Oppong, 1998). Understanding the myriad factors that make

vulnerable groups more susceptible to HIV can help strengthen public health initiatives by tackling the underlying causes of vulnerability and incorporating targeted initiatives to address the enablement and empowerment of vulnerable people (Oppong,1998).

**Figure12.1: Vulnerability Perspective and HIV/AIDS** Vulnerability to HIV Transmission

Individual Susceptibility Exposure Structural Forces

Political and Economic Systems  
Economic Factors  
Entitlement and empowerment

Social Systems and  
Power Relations

Social Factors Cultural Factors

Marginalization of Cultural norms, stigma,

social groups discrimination

Source: Diagram based on the works of Oppong, 1998; Wisner at al., 2004

Economic vulnerability is related to a person’s entitlement and empowerment, which when

Compromised, limits the availability of resources. As explained by Watts & Bohle (2019), adverse circumstances like disease do not affect groups uniformly and this can be tied to economic factors (1993). On a large scale, economic vulnerability can be influenced by the outside forces of structural adjustment. As Mayer (2005) notes, the increased structural adjustment policies in sub-Saharan Africa aimed at increasing the economic growth of countries in reality has led to the weakening of their health infrastructure as resources have been reallocated to larger economic projects (2005). Through this, economic growth in other sectors has indirectly increased the vulnerability of populations by preventing them from accessing the necessary medical services to prevent the onset of the HIV epidemic.

Similarly, socioeconomic status within society can determine the degree of access populations have to resources. For example, poverty is one of the largest economic determinants, and as poverty limits the number of resources available, it can have severe impacts on the ability for populations to protect themselves from disease. As a result, economic circumstances that determine an individual’s entitlement to resources can make individuals more biologically susceptible (Kalipeni *et al,* 1998).

Through these structural forces that perpetuate economic vulnerability, individuals are forced to partake in risky behavior in order to gain access to necessary resources (Oppong, 1998). Oppong’s case study (1998) of HIV prevalence in Ghana, poor economic conditions in Ghana have caused women in Ghana to become actively involved in the commercial sex industry with neighboring Cote d’Ivoire. Their actions consequently increase their risk to HIV, yet without alternative means to acquire resources, their economic circumstances influence their vulnerability to HIV.

In addition to economic vulnerability, the vulnerability perspective looks at how social systems and power relations impact risk through social and cultural factors. One important aspect is the marginalization of social groups and how through social vulnerability, populations become more prone to contracting the disease (Oppong, 1998). One of the most prominent examples is the relationship between HIV and gender as shown in the disproportional impact of HIV/AIDS on women in sub-Saharan African. For example, in Ghana, the sex ratio of HIV/AIDS cases is a staggering 5 female: 1 male, which is extremely unusual (Oppong, 1998). This ratio can be attributed to the lower status of women within society, which decreases their autonomy and negatively impacts their access to resources. This pattern can be seen across other countries as well, where women lack the independence to practice safe sex behavior or access to medical services due to their low status in society. This power differential consequently increases their vulnerability to HIV by limiting the efforts they can take to protect themselves.

Similarly, cultural factors can be the most influential in increasing vulnerability by impacting the cultural framing of disease (Craddock, 2000). Within the cultural framing of disease, knowledge is constructed that creates lasting impact on the way a society reacts to and engages with health and disease. As Craddock (2000) argues, powerful cultural factors cause disease to be “culturally constructed and socially deployed”. Through cultural narratives and norms, ideals surrounding behavior (and in the specific case of HIV/AIDS, expressions of sexuality and promiscuity) inevitably determine the way HIV/AIDS is perceived within a society. These cultural constructions can selectively impact which social groups become more vulnerable, as well as the way that society deals with a disease, by providing barriers to communication and ultimately prevention. Acknowledging how these cultural barriers are constructed through the inter-play of local, state and global economies of power is essential in order provide to effective ways to deal with the epidemic

Cultural narratives and norms also inevitably result in stigma and discrimination surrounding this virus and those affected with it (Craddock, 2000). As a result, one the of biggest challenges in addressing the HIV/AIDS pandemicis attempting to deconstruct the misconceptions surrounding the virus. Because HIV is most commonly transmitted by bisexualacts, the disease is often a tabo topic. This frequently stifles discussion around HIV/AIDS or even silences it, which ultimately hinders prevention efforts by isolating vulnerable individuals and preventing them from seeking necessary education and treatment (UNAIDS, 2003). This stigmatization of the disease has led increased discrimination against infected individuals, creating a vicious cycle that prevents HIV positive individuals from receiving the care they need and therefore increasing their vulnerability and the vulnerability of those in their communities.

Looking specifically at differential access to resources resulting from social, economic and political factors, the vulnerability perspective provides important insight into understanding how the spread of HIV/AIDS is influenced by non-biological factors. Shifting emphasis from individual behavior to social structures that cause individuals to participate in risky behavior helps to identify risk environments. Recognizing these risk environments allows for the realization of how social processes place populations in risky circumstances (Rhodes et al., 2005). This acknowledgement that risk is no longer a purely biological entity is extremely important to acknowledge especially in public health initiatives, in order to ensure that solutions are proposed to remove the economic, social and cultural obstacles through appropriate structural changes (Oppong, 1998). Ensuring that the underlying causes of vulnerability are addressed will help the success of information-based programs by providing parallel initiatives to address the enablement and empowerment of vulnerable populations (Oppong, 1998).

**2.3 Forced Migration**

With the increasing number of conflicts around the world, the number of refugees and displaced persons are of growing concern. In 2007, worldwide there were 25.1million refugees and internally displaced persons, with 2.5 million new refugees in 2007alone. This is a staggering increase from 19.2 million persons in 2005, highlighting the growing need for durable solutions to address conflicts that are continuing to increase the number of refugees (UNHCR, 2008). Further complicating the issue is the growing number of refugees in the developing world. With the majority of refugees located in areas with limited resources, this further complicates access to necessary resources and the distribution of humanitarian aid.

The rights and status of refugees are defined by a number of international treaties and conventions (UN, 1967). States that ratify these instruments have the responsibility to provide the appropriate protection and rights defined within the convention such as determining refugee status, providing identity documents and ensuring human rights (Bailey, 2004). The first United Nations Convention Relating to the Status of Refugees took place in 1951 with the Protocol Relating to the Status of Refugees coming into effect in 1967.

From these two legal conventions the term “refugee” was defined as any person who:

Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular group or political opinion, is outside the country of his nationality and is unable or owing to such a fear, unwilling to avail himself of the protection of that country (A 1 (2)). (UN, 1967);

This definition, focusing on individual persecution was modified in 1969 by the organization of African Unity to include people wh Owing to external aggression, occupation, foreign domination events seriously or disturbing public order in either part of the whole of his country of origin or nationality, is compelled to leave hi place of habitual residence in order to seek refuge in another place outside of his country of origin or nationality (Art. 1 (2)) (OAU, 1969).

Expanding the definition to include individuals fleeing en masse from their country of origin allowed for the basis of recognizing groups of refugees rather than just granting individual claims (Bailey, 2004). As a result, many refugees, especially when entering African states, are recognized on the basis of prima facie and this results in the ability to grant refugee status to large numbers refugees fleeing to refugee camps (Bailey, 2004).

Under Article 23 of the 1951 Convention, host countries are expected to provide “equal and non-discriminatory access to existing health services for refugees” (UNAIDS *et al.,* 2005). This, in conjunction with international human rights law, requires countries to provide individuals with the highest attainable standard of physical and mental health. However, despite this mandate, “health care” is not defined within the Convention, which leads to major discrepancies in interpretation between curative and preventative care (Eidenier, 2006). In regards to HIV/AIDS medical services the situation is even more abstract. Countries seldom include the HIV-related needs of refugees within their National Strategic Plans since countries already overburdened with HIV/AIDS within their own population are usually unwilling to provide additional services and do not include refugees in their National AIDS Policies (UNAIDS *et al.,* 2005). This leaves refugees in an extremely vulnerable situation as they may not have access to HIV-testing, antiretroviral therapy or even basic HIV education and prevention strategies (UNAIDS, 2005). This is not only discriminatory but undermines prevention efforts within the country. Consequently, the integration of refugees into National AIDS Programs (NAPs) as well as the cooperation between host countries, intergovernmental organizations and nongovernmental agencies, is seen as a vital step towards helping HIV-positive refugees.

**2.4 Epidemiology of HIV/AIDS in Sub-Saharan Africa. Avoid putting full stops at the end of the sub-heading**

Sub-Saharan Africa remains the hardest-hit region in terms of HIV infection is becoming endemic in sub-Saharan Africa, which is home to just over 12% of the world’s population but two‑  
thirds of all people infected with HIV. The adult HIV prevalence rate is 5.0% and between 21.6  
million and 24.1 million total are affected (UNAIDS, 2011). However, the actual prevalence varies  
between regions. Presently, Southern Africa is the hardest hit region, with adult prevalence rates  
exceeding 20% in most countries in the region, and 30% in Swaziland and Botswana. Analysis of prevalence across sub-Saharan Africa between 2000 and 2017 found high variation in prevalence at a sub national level, with some countries demonstrating a more than five-fold difference in prevalence between different districts (Dwyer-Lindgren *et al,* 2019).

Eastern Africa also experiences relatively high levels of prevalence with estimates above 10% in some countries, although there are signs that the pandemic is declining in this region. West Africa on the other hand has been much less affected by the pandemic. Several countries reportedly have prevalence rates around 2 to 3%, and no country has rates above 10%. In Nigeria and Côte d'Ivoire, two of the region's most populous countries, between 5 and 7% of adults are reported to carry the virus (Dwyer-Lindgren *et al,* 2019).

**Table 2.1. Estimated Number of People in the African “AIDS Belt” Living with HIV/AIDS , end of 2001**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total Adults and**  **Children** | **Total Women (15 -49)** | **Adults (15-49) rate**  **(%)** |
| Global Total | 40 million | 18.5 million | 1.2 |
| Sub-Saharan Africa | 28.5 million | 15 million | 9.0 |
| Djibouti | – | – | – |
| Ethiopia | 2.1 million | 1.1 million | 6.4 |
| Uganda | 600,000 | 280,000 | 5.0 |
| Kenya | 2.5 million | 1.4 million | 15.0 |
| Tanzania | 1.5 million | 750,000 | 7.8 |
| Rwanda | 500,000 | 250,000 | 8.9 |
| Burundi | 390,000 | 190,000 | 8.3 |
| Mozambique | 1.1 million | 630,000 | 13.0 |
| Malawi | 850,000 | 440,000 | 15.0 |
| Zambia | 1.2 million | 590,000 | 21.5 |
| Zimbabwe | 2.3 million | 1.2 million | 33.7 |
| Namibia | 230,000 | 110,000 | 22.5 |
| Botswana | 330,000 | 170,000 | 38.8 |
| Swaziland | 170,000 | 89,000 | 33.4 |
| Lesotho | 360,000 | 180,000 | 31.0 |
| South Africa | 5.0 million | 2.7 million | 20.1 |

**Source: UNAIDS, Report on the Global HIV/AIDS Epidemic: July 2002.**

According to UNAIDS, all the worst affected countries (with prevalence rates over 20 percent) are contiguous to one another in the lower part of the continent. These include South Africa, Lesotho, Swaziland, Botswana, Namibia, Zambia, and Zimbabwe. Botswana, Lesotho, Swaziland, and Zimbabwe have prevalence rates above 30 percent.

Further north in the AIDS belt, Mozambique, Malawi, Burundi, Rwanda, Kenya, Tanzania, and Ethiopia all have adult prevalence rates in the 6-15 percent range. Adult prevalence in Uganda is estimated to be around 5 percent. Uganda is the one country in the region that has probably achieved a longstanding decline in HIV prevalence. Prevalence in Uganda may have peaked in the 12-13 percent range in the early 1 990s before the onset of this decline (Timberg, 2007).

Elsewhere, Somalia, Eritrea, Djibouti, and Sudan have little or no data, and Madagascar remains an interesting case. Despite tourism, an active commercial sex trade, and high rates of other sexually transmitted infections (STIs), and despite being separated from the African mainland by only 60 KMs of water, adult HIV prevalence remains below 1 percent (Timberg, 2007).

Though having overall adult prevalence rates lower than in the eastern and southern parts of the continent, the middle part of Africa is undergoing a serious and generalized HIV/AIDS epidemic. Among the countries in the region, the Democratic Republic of Congo, Chad, and Equatorial Guinea show adult HIV prevalence rates under 5 percent. Angola has been war-torn and chaotic for so long that it is difficult to know exactly what is transpiring with the epidemic there. However UNAIDS places the adult prevalence rate at 5.5 percent. Elsewhere in the region, UNAIDS rep prevalence rates of 7.2 percent in the Congo, 11.8 percent in Cameroon, and 12.9 percent in the Central African Republic. Many of the worst affected countries in middle Africa have the hig rates of other STIs on the continent (Timberg, 2007).

Though across Sub-Saharan Africa, more women are infected with HIV than men, with 13 women infected for every 10 infected men. This gender gap continues to grow. Throughout the region women are being infected with HIV at earlier ages than men. The differences in infection levels between women and men are most pronounced among young people (aged 15–24 years). In this age group, there are 36 women infected with HIV for every 10 men (Timberg, 2007). The widespread prevalence of sexually transmitted diseases, the promiscuous culture, the practice of scarification, unsafe blood transfusions, and the poor state of hygiene and nutrition in some areas may all be facilitating factors in the transmission of HIV-1 (Bentwich *et al.,* 1995).

HIV is a retrovirus that attacks the T-helper cells in the human immune system. This leads to the weakening of the human immune system causing individuals to become more susceptible to disease and eventually unable to fight off infection (CDC, 2008). HIV is transmitted through the exchange of bodily fluids that contain the retrovirus, including blood, semen, vaginal fluids and breast milk. The virus enters the body either directly through the bloodstream or by passing through delicate mucous membranes. Once HIV enters the human blood stream, the retrovirus begins to proliferate through the body and in response; the immune system creates antibodies to the virus. The main methods of transmission are unprotected sexual intercourse with an infected partner, infected blood transfusion, the sharing of infected needles and transmission from mother to child either through labor or breast-feeding (WHO, 2008).

Currently the only HIV testing routinely available looks for the presence of HIV antibodies in the blood stream (CDC, 2008). However, it can take anywhere from six weeks to twelve months for HIV antibody levels to reach a threshold that can be detected within this blood test. This “latency period” of the immune response creates a huge challenge for the prevention of HIV since HIV infected individuals can be tested for HIV but not test positive for an extended period of time. This leaves many unaware of their status, preventing them from taking appropriate precautionary measures to protect themselves and others (CDC, 2008).

When a person is HIV positive, HIV antibodies are present in their bloodstream, and as the virus continue to replicate in the body, the number of T-helper cells decreases thus weakening the immune system (CDC, 2008). Once the level of T-helper cells in the bloodstream reaches 200 hundred/μL or 400 hundred/μL with the presence of an opportunistic infection, a patient is diagnosed with Acquired immune deficiency syndrome (AIDS). With a compromised immune system, they are unable to fight off common diseases and therefore become more prone to opportunistic infections like tuberculosis (TB) or pneumonia. While there is currently no cure for HIV infection or AIDS, individuals can prevent the onset of AIDS through antiretroviral drug therapy (ARVs). ARVs are drugs that specifically target the proliferation of the virus through the blood stream by preventing the retrovirus from replicating. The main types of ARV treatment include ARV prophylaxis and long-term treatment (UNAIDS 2005). ARV prophylaxis is a shorter medicine regime that is prescribed in situations to prevent transmission after limited exposure. For example, ARV prophylaxis is generally given to rape victims or to mothers and infants before and after labor to prevent mother-to-child transmission. Long-term ARVs on the other hand are given to patients infected with HIV to prevent the onset of AIDS by keeping the levels of the virus and t-cells controlled (UNAIDS 2005).

There are two strains of HIV: HIV-1 and HIV-2, with HIV-1 being responsible for the majority of HIV cases worldwide (Mayer, 2005). The difference between these two strains can be mainly attributed to the biological structure of the retrovirus, withHIV-2 being a less virulent strain that is harder to transmit and slower acting. While HIV was globally recognized in 1981, HIV-1 was not isolated until 1983. Two years later in1985, HIV-2 was first identified (Kalipeni, 2004). Both of these strains have been biologically characterized and traced to have originated in Central Africa (Mayer, 2005).HIV- 1 in particular is structurally similar to simian deficiency virus (S IV) a similar immunodeficiency virus in chimpanzees whereas HIV-2 is similar to SIV in Sootymangabeys (Mayer, 2005). Despite the biological similarities, how the virus mutated and transferred from the primate to human population remains unknown.

**2.5 Refugees, HIV/AIDS and Vulnerability**

Refugees are particularly vulnerable to HIV/AIDS, and addressing their medical needs is essential to carrying-out an effective public health effort against HIV/AIDS. Although this topic has been gaining importance over the last decades, there continues to be limited literature available on the relationship between HIV/AIDS and refugees. Studies that are available acknowledge that as a marginalized group refugees can be inherently more vulnerable to HIV/AIDS, which is exacerbated through the loss of social stability and exposure to conflict (Spiegel, 2004). However due to the circumstantial nature of forced migration, the relationship between forced migration and HIV/AIDS depends on a variety of factors related to the specific circumstances of the refugee population and host countries.

The relationship between HIV/AIDS and forced migration is very complex and there is a multitude of factors that both increase and decrease refugees’ vulnerability (Spiegel, 2004). Factors that increase vulnerability disrupt access to resources consequently impacting treatment, prevention efforts and coping mechanisms. These include the loss of physical, financial and societal security and the increase of sexual violence (Spiegel et al, 2004). Behavioral changes to deal with lack of income and instability can also occur, including transactional sex or increasing drug use, which can greatly increase the spread of HIV if the necessary preventative measures are not taken (UNAIDS *et al.,* 2005). Finally, the reduction in health and educational resources and services prevents refugees from taking the necessary preventative measures to stop the spread of HIV severely undermining prevention efforts for the entire community (Spiegel, 2004).

On the other hand, forced displacement can sometimes decrease vulnerability by decreasing exposure to HIV by reducing mobility as well as increasing access to services from humanitarian organizations. Refugees in refugee camps are confined within the boundaries of the camps, which can reduce their mobility, preventing them from being exposed to populations outside of the camp that may have higher HIV prevalence. As a result, refugees are less exposed to high-risk activities of prostitution or injection drug use that may increase HIV transmission (Spiegel, 2004). Refugee camps may also provide better HIV/AIDS services for refugees as compared to what was available in their countries of origins. While HIV services are not always provided in emergency response situations, long-term occupants of refugee camps may have better access to condoms or HIV testing that can actually allow refugees to take more preventative measures against the spread of HIV (Timberg, 2007).

Ultimately, however, the vulnerability of refugees depends on HIV prevalence gaps between populations and whether or not refugees enter higher-or-lower risk environments (Spiegel, 2004). From this, the level of interaction between populations determines whether or not forced migrants are more vulnerable. For example, if refugees enter a country where the HIV prevalence is higher than that of their country of origin, their vulnerability is increased as they face greater exposure to HIV from the host population. Studies have shown that in general refugees migrate from countries with lower prevalence compared to the HIV prevalence of host countries (Spiegel, 2004).

With the vast number of competing and inter-related factors that impact the vulnerability of refugees, it is essential to use temporal and context-specific circumstances to understand how to guide HIV policies and programs (UNAIDS *et al.,* 2005). Specifically, acknowledging and tracking the HIV prevalence among refugees and host populations is imperative both for the safety of the forced migrants and local populations to ensure effective preventative measures are designed and implemented. The availability of resources is also important to monitor, especially for refuges not living in refugee camps, since the material support for these individuals can be very limited (Spiegel, 2004).

**2.6 Policies Addressing HIV/AIDS and Refugees**

Until 1990, there was very little policy emphasis on the medical needs of HIV positive refugees. At the time, HIV prevention and response was considered secondary to the emergency response of providing shelter, food and protection, needed in refugee camps in war-torn areas. In addition, there was a fear that highlighting the needs of HIV positive refugees would cause host countries to reject refugees out of fear of spreading the virus (Spiegel *et al,* 2005). However, as the immediate needs and importance of addressing HIV concerns have arisen, new policies have been implemented to address these issues. UNHCR and UNAIDS are the biggest actors in addressing the issue of HIV/AIDS and refugees. They work in coordination with governments to help create appropriate responses to refugee situations and provide the best and necessary HIV/AIDS related care for refugees (UNAIDS *et al.,* 2005).

In the early 1 990s, the protection mandate, “Policy Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)” was published by UNAIDS and mandated that refugees could not be expelled from a country based on their HIV status (UNHCR, 1990). Published in response to the growing practice of testing refugees for HIV before allowing them to travel internationally or apply for resettlement, this was the first policy to specifically target the issue of refugees and HIV/AIDS. Since then, UNHCR has continued to publish guidelines and strategic plans emphasizing the rights of refugees with regards to HIV and AIDS, including discouraging the use of mandatory testing and emphasizing the human rights of refugees.

According to UNHCR and UNAIDS protocol, there are three main time periods that determine the response to tackle the HIV-related needs of refugees (UNAIDS *et al*.,2005). The first phase is the emergency phase where the Inter-agency Standing Committee recommends a minimum set of interventions. These include:

1. Establishing coordination mechanisms;
2. Providing access to basic health care for the most vulnerable people;
3. Providing a safe blood supply;
4. Adhering to universal precautions;
5. Providing basic HIV education materials;
6. Providing condoms;

Offering syndrome sexually transmitted infection treatment; (viii) Providing appropriate care for intravenous drug users;

1. Managing the consequences of sexual violence and
2. Ensuring safe material deliveries (UNAIDS *et al.,* 2005, 5).

This initial response is particularly important as it is at this phase where refugees can be especially vulnerable due to the deprivation of housing, food, security and health services and information.

The second phase revolves around post emergency or stabilization conditions where more comprehensive interventions can be used to prevent HIV transmission as well as provide the necessary support, care and treatment of HIV-positive persons (UNAIDS *et al.,* 2005). Current recommended interventions include expanding comprehensive programs to prevent sexual violence, providing post-exposure prophylaxis ARVs, distributing education materials about HIV and providing voluntary confidential counseling and testing (VCCT) as well as services to prevent mother-to-child transmission. In ideal situations, this second phase would also provide necessary ARV therapy or the treatment of opportunistic infections in AIDS patients.

Whereas the two previous phases dealt with the provision of necessary HIV related medical care and education, the last phase focuses on durable solutions that include repatriation, local integration and resettlement (UNAIDS *et al.,* 2005). These solutions provide means to prevent HIV positive refugees from feeling vulnerable or isolated through this transitory phase. Part of these durable solutions requires that in order to prevent discrimination due to their HIV status, refugees are not forced to undergo mandatory testing or disclose their HIV status. Another issue is ensuring continued access to HIV/AIDS services for refugees once resettled or repatriated. Continuing ARV therapy is especially important since changes or lapses in this regime can significantly impact the medical progress of an individual (Spiegel, 2004). In response to these challenges, UNHCR and UNAIDS suggest that interventions should include continuing prevention efforts in refugee camps, public information campaigns, especially for refugees returning to areas with limited HIV programs, and comprehensive education campaigns to ensure that HIV status is not an issue for refugees attempting to repatriate, resettle or integrate into the local population (UNAIDS *et al.,* 2005).

Despite the extensive list of recommended interventions, one of the biggest obstacles to providing necessary medical care and prevention efforts to refugees is the lack of resources available for these situations (UNAIDS et al., 2005). While humanitarian organizations do have some funding to provide emergency response interventions, especially for those recommended in the secondary phase, which are often more comprehensive, funding is limited and often inadequate. From this stems the question of who is ultimately responsible for the HIV-related needs for refugees, especially with regards to VCCT and ARV (Spiegel, 2004). As mentioned previously, many countries that host refugees are already overburdened by the HIV/AIDS epidemic and do not have the necessary means to provide additional services for a temporarily displaced population. In addition, due to prevalence gaps between populations, the HIV related needs of refugees and host populations may not always match resulting in a discrepancy in available services. As a result, the majority of countries do not include refugees in their National AIDS Programs. These actions not only limit the availability of HIV/AIDS services for refugees, but also undermine national prevention efforts by ignoring the needs of a high-risk group. Importantly, this inaction inevitably places both refugee and host populations at greater risk to HIV.

Apart from developing policies to address HIV-related needs of refugees in emergency situations, in 2005 UNHCR and UNAIDS collaborated to develop specific strategies for countries to adopt to help address the HIV/AIDS -related needs of refugees on a long-term basis. Through the publication of guidelines for governments and humanitarian organizations, this initiative was the first to propose comprehensive long-term solutions to the HIV/AIDS -related needs of refugees. Entitled “Strategies to support the HIV-related needs of refugees and host populations”, the proposal outlines the three “best practices” for refugee-hosting countries which include: integrating refugee issues into national health and HIV programs, implementing sub-regional initiatives and combining funding streams (UNAIDS *et al.,* 2005).

The first recommended initiative is the integration of refugee health issues into national health and HIV/AIDS programs. Over recent years, as conflicts have increased in complexity and scope, the average duration of refugee situations has increased from nine to 17 years (UNAIDS *et al.,* 2005). As a result, host governments are increasingly responsible for the needs of refugees for longer periods of time and ignoring their presence undermines prevention efforts. UNHCR and UNAIDS recommend that National AIDS Programs should integrate refugees into their national health programs since this brings benefits to both the host population and refugees. First of all, integration can provide additional resources from humanitarian organizations to the country that would have previously been allocated to refugees. By combining programs, it prevents the formation of parallel services between national and refugee populations, which can lead to an inefficient use of funding. Through this, local health-care services can be improved since additional resources can be invested in specific areas strengthening the scope of the health sector. On the other hand, for the refugee population, this solution removes barriers in accessing necessary health care services. Not only would refugees have better access to VCCT and ARV therapy, but through an integrated system the perception that “HIV is not in our community, but their community” could be removed by creating a dialogue between the two populations and, ideally, decreasing stigma and discrimination (UNAIDS *et al.,* 2005, 19).

A second more innovative approach is the implementation of sub-regional approaches. Responding to the realities of disease and migration, these approaches address the fact that HIV “crosses borders” and that the diffusion of HIV through migration must be addressed (UNAIDS *et al.,* 2005, 21). Sub-regional approaches provide a solution that ensures regions have a more standardized system of care, allowing populations in that geographic region to provide equal standards of care. Consequently, refugee populations throughout the region can access the same standard of HIV-related care through the education, testing and treatment facilities implemented throughout the region. This initiative strengthens prevention efforts by providing continuity in the services available, as well as decreasing the vulnerability of marginalized groups (Timberg, 2007).

National programs also gain from this initiative since the HIV/AIDS services within the sub-regional approach would also be targeted towards the national populations. This would lower costs by creating a more efficient system of care and treatment, as well as creating opportunities for

additional funding from humanitarian organizations (UNAIDS *et al.,* 2005). Finally, this solution would also encourage the dialogue surrounding HIV/AIDS in the region, by providing an avenue for policy makers in the region to come together to discuss prevention methods and education initiatives to combat stigma and discrimination.

The last approach suggested is the combination of humanitarian and development funding to provide better resources for HIV/AIDS -related needs of refugees by increasing the availability of education, testing and treatment services (UNAIDS *et al.,* 2005). Similar to the other two solutions, this practice would ensure that HIV/AIDS services for host and refugee populations were not being duplicated or funding was not lost by coordinating and aligning humanitarian and development funds. Through this, humanitarian aid could be used to complement development aid for HIV

interventions thus improving the availability of services for both populations. Combining these two funding streams would also lead to an increase of funding, meaning that together initiatives could target both short and long-term programs that were previously out of reach.

Current studies of refugees in East Africa have highlighted how implementing the UNHCR/UNAIDS proposed initiatives can improve the availability of HIV/AIDS services for refugees. One of the most well-known sub-regional initiatives is the Great Lakes Initiative on AIDS (GLIA). The Great Lakes Region does not only suffer from high HIV prevalence of 4.1% - 8.8%, but has also been the site of intense conflict resulting in large numbers of refugees fleeing from Rwanda, Burundi and the Democratic Republic of Congo to the neighboring countries of Kenya, Tanzania and Rwanda (UNAIDS *et al.,* 2005). Due to the high number of refugees continually crossing borders, the governments saw that a regionally focused response was needed to help attempt to halt the spread of the virus as well as create a higher standard of care for all refugees (UNAIDS *et al.,* 2005).

The Great Lakes Initiative on AIDS was developed in 1999 and has four main components: HIV support to refugees, support to HIV-related networks, support to regional health-sector collaboration and a managing and evaluating sector. Although still relatively new project, benefits have been noticed including a stronger relationship between government, the UN, NGOs and bilateral and multilateral donors. But most importantly refugees now have better access to health care through HIV-related medical sites specifically for refugees in every country (UNAIDS *et al.,* 2005).

Apart from medical services prevention efforts are also benefiting from these UNHCR/UNAID proposed strategies. Tanzania, a member of GLIA, has begunto integrate refugees into their national prevention programs, which is having important benefits in increasing prevention throughout the country (UNAIDS *et al.,* 2005). A recent case study has shown that in Kobondo refugee camp in Tanzania, a local refugee organization, Stop AIDS, has begun to work with the Tanzanian Service Healthand Development for People Living with HIV/AIDS. This coordination between a refugees and local population organizations works to provide HIV awareness and education to both refugees and the surrounding communities. This initiative has been very successful in organizing school activities, concerts, mass campaigns and public speakers. As a result, not only is HIV awareness increasing, but the cooperation of a local organization with a refugee organization, decreases the stigma surrounding the refugee population.

Although UNHCR and UNAIDS have made significant progress in addressing the issue of HIV/AIDS and refugees, the literature available primarily looks at response initiatives and programs in emergency situations. These initiatives are clearly beneficial and while they do discuss the factors that influence HIV risk of refugees, they fail to fully acknowledge the structural factors that influence the relationships between HIV/AIDS and refugees. Instead, these initiatives simply

focus on the technical implementation of programs instead of the theoretical reasons behind them. This lack of outside scholarly research needs to be addressed in order to build a more extensive body of literature and analyze the effectiveness of these programs. Continued research would also help build a greater understanding of HIV-related needs of refugees in different situations in an attempt to further understand the relationship between HI V/AIDS, refugees and access to medical care.

**CHAPTER THREE: METHODOLOGY**

**3.1 Research design**

The research was an exploratory/formularizes a cross sectional design since data was got from one organization which Bidibidi refugee settlement camp in North-western Uganda. This is home to over 270,000 South Sudanese refugees since July 2016. In the selected design the research was about investigating, explaining and describing the phenomenon of interest through obtaining different viewpoints relating to the objectives.

Since this study was a cross sectional, both quantitative and qualitative methods were used in order to generalize the findings of the study in accordance to the objectives. At the same time, it also aimed at exploring the real or have a significant insight into the situation and/ or phenomenon concerning South Sudanese refugees, HIV/AIDS and accessibility to medical care in northwestern

**3.2. Study population and sample size**

Study population is the entire population among whom the study was conducted (Day, 2008). The study population is also taken to mean a group of individuals from the general population that share common characteristics such as age, gender or health conditions. The study population 30 included the NGOs officials who work directly with Bidibidi Refugee settlement camp. The target population included a total population of 210 respondents constituting of 40 NGO officials; 40 refugees’ leaders, 80 refugees living with HIV/AIDS, 20 Health officials and 30 political leaders.

The sample size of the study was selected using Krejcie and Morgan table for sample determination as indicated under appendix III. The sample size included a total population of 132 respondents constituting of 21 NGO officials; 421 refugee’s leaders, 57 refugees living with HIV/AIDS, 13 Health officials and 20 political leaders.

**Table13.2: Sample Size**

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization** | **Category** | **Population** | **Sample size** |
| **NGOs** | NGO Officials | 40 | 21 |
| **Refugees** | Refugees Leaders | 40 | 21 |
| People living with  HIV/AIDS | 80 | 57 |
| **Government** | Health Officials  political leaders | 20  30 | 13  20 |
| **Total** |  | **210** | **132** |

**Source: Primary Data (2021).**

**3.3 Data Collection Methods and Instruments**

Both primary and secondary sources of data collection were used during this study.

**3.3.1 Secondary Data Sources**

Secondary data was obtained from text books, Journals, News Papers, reports as well as internet sources. Secondary data was therefore be used to enrich the research with literature and knowledge basing on theories, making critiques and ease to analysis of the collected data. Since secondary source of data collection has weaknesses such as out-datedness with time; this prompted the researcher to conduct a field study and hence be able to get primary data for this study.

**3.3.2 Primary Data Sources**

This involved the extraction of firsthand information from the field of investigation. In interest to this particular study, questionnaires and interviews were used for primary data collection.

**Questionnaire**

A questionnaire is a series of questions designed to obtain statistically useful information about a given topic (Groonos, 2007). Survey is preferred because it is an appropriate instrument for any survey research and is popular with researchers because information was obtained fairly, easily and the questionnaire responses are easily coded.

**Interviews**

Interviews involved engaging participants in a face-to-face conversation with an interview guide focused on questions related to the research study. The participants were asked specific questions related to the study objectives for their thoughts, opinions, perspectives or descriptions of special experience. The reason for this choice was based on the anticipation about an availability and time for potential participants. Thus, the interview method was used to ease data gathering because o its flexibility, yet with delimited generality, and allowance it can give to the interviewee responding as they deemed important. For this particular study, interviews were purposive for example humanitarian representatives operating in Bidibidi as they are key informants to the stud

Since new findings were important as they provide insight into a phenomenon that has no previously been documented. Interviews in this type of research was conducted surrounding HIV/AIDS services for refugees since there are still many questions unanswered about the relationship between forced migration and HIV/AIDS. Looking at services specifically for South Sudanese refugees are particularly not clear and therefore this research was not only providing a better understanding of the situation but also begin a dialogue surrounding the circumstances facing South Sudanese refugees. With this there is an impetus for future policy changes as well as the potential to bring lessons from Bidibidi refugee settlement camp and apply them to other countries where refugees face similar challenges.

**Observation**

Observation as an instrument of research involved the use of vision as a means of data collection. It involved the selection, provocation, recording and encoding of the set behavior and concern through empirical methods. Observation as a method was also generally be used to collect data of the current situation and issues majorly observed included the sexual behaviors of all demographics, HIV/AIDS treatment facilities and other vulnerabilities etc.

**3.4 Validity and Reliability**

For purposes of data validity and credibility, the research employed both data source and methodological triangulation this is because various data sources were employed to ensure data source triangulation and various data collection methods was applied one after the other to increase confidence in interpretation.

The research also employed a subject review (also called “member checking” and “dialogue with participants”). In this scenario, I solicited for a lecturer’s or any other participant’s views of the credibility of interpretation and findings.

The dependability/ reliability also was achieved through data archiving/Creating an Audit trail. In this case, the researcher ensures the completeness and accuracy of documents (e.g. interviews, observations, etc.) and being clear about the coding schemes and data analysis process. Theoretically, this allowed someone not connected with the study to review the primary documents and coding schemes to assess whether the findings, interpretations, and conclusions are supported.

The dependability/reliability also was achieved through “Skeptical Peer Review”. The skeptical peer review played the role of devil’s advocate, asking difficult questions about methods, meanings, and interpretation of the data. Therefore, this process provided an external check on the research.

**3.5 Data Analysis**

The research relied on background experience and the literature to present the evidence in various ways, using various interpretations. This was done in a way that was not bias the results.

But in this case of a cross sectional design these simple steps ensured robust data analysis: The collected unstructured data from the field, was transcribed or converted into textual form.

Secondly, organizing research data according to research objectives/questions in a visually clearway this was achieved through use of tables that is by inputting research objectives into the table and assigning data according to each objective.

Thirdly, coding research data or compressing data into easily understandable concepts. This actually involved categorizing data into concepts, properties and patterns most crucially coding was achieved descriptively allowing summarizing the central theme of your data.

**3.6. Ethical Considerations**

First there was prohibitions against fabricating, falsifying, or misrepresenting research data promote the truth and avoid error. Second, since this research involved a great deal of cooperation and coordination among many different people in different disciplines and in stitutions, ethical standards therefore promotion of values was essential to ensure collaborative work, such as trust, accountability, mutual respect, and fairness.

The respondent’s names were withheld to ensure anonymity and confidentiality in terms of any future prospects. In order to avoid bias, the researcher interviewed the participants one after the other and ensured that he informs them about the nature and extent of his study and on the other hand the researcher gave them reasons as to why she was interviewing them.

**CHAPTER FOUR: DATA PRESENTATION, INTERPRETATION AND ANALYSIS**

**4.0 Introduction**

This chapter contains data interpretation and analysis on HIV/AIDS and accessibility to medical care in Bidi-Bidi Refugee Settlement Camp in Northwestern Uganda.

The researcher distributed 132 questionnaires, however, only 126 were filkled and returned making response rate of 95%. The researcher obtained data on respondents’ personal variables, the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp, the refugees’ vulnerability to HIV/AIDS in Refugee settlement camps and policies addressing HIV/AIDS and Refugees and how HIV/AIDS related health care services were explored in Bidibidi refugee settlement camp.

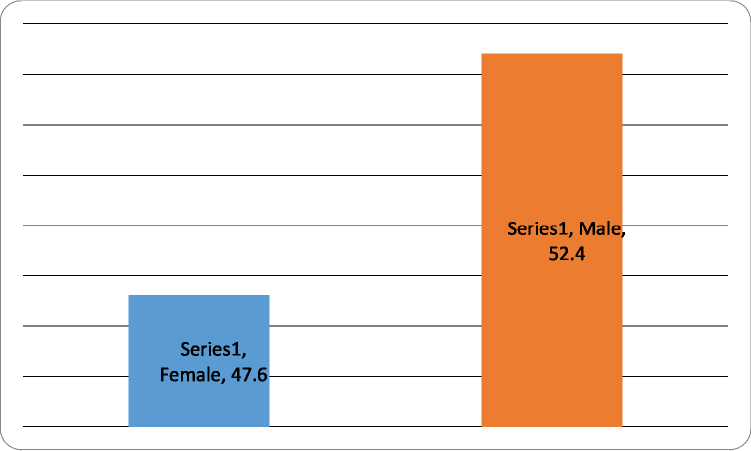
**4.1 Respondents’ personal data**

In research, personal variables help to explain and relate the opinions and composition of respondents to the findings of the study. In this research the respondents’ data include gender, age and education level and period stayed in Bidibidi Refugee settlement camp.

**4.1.1. Gender**

As both male and female were important, the study asked respondents to state the gender and the

results are presented in figure 4.1.



**Source: Primary data, 2021**

**Figure3 4.1: Gender**

From Figure 4.1 60 (47.6%) were females and 62 (52.4%) were males. Majority of the respondents that is 52.4% were males which implies that males were more supportive and ready to provide data to support the study compared to the females (despite being more than males in the numbers though also the percentage of females at 47.6% was a considerable level of response. But the fact is that, the percentage of male and female is almost the same, it implies that the information collected during the study almost equally represents both sexes of the refugees in Bidibidi.

**4.1.2. Age of the respondents**

Maturity determines the level of reasoning of a person and therefore, study asked respondents to state their age and the results are presented in Table 4.1.

**Table3 4.1: Age**

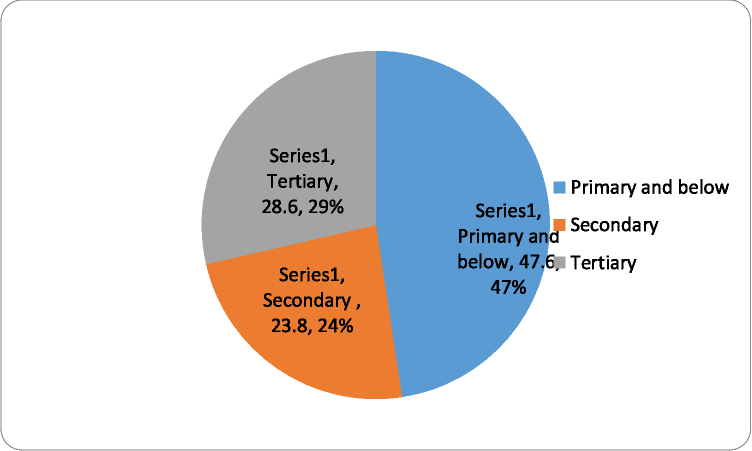
|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| 15-30 | 18 | 14.3 |
| 31-45 | 84 | 66.7 |
| Valid  46 and above | 24 | 19.0 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

From table 4.2, 18 (14.3%) of the respondents were aged 15 to 30 years, 84 (66.7%) were aged 31 to 45 years and 24 (19.0%) were aged 46 years and above. For most active refugee respondents were aged 31 to 45 years; though all respondents availed data for this study.

**4.1.3. Education level**

Education level determines whether the respondents understand the research language, thus the study asked respondents to state their education level and the results are presented in Figure 4.2



**Figure44.2: Education level Source: Primary data, 2021**

From Figure 4.2, 60 (47.6%) of the respondents had attained no education or primary education, therefore had limited knowledge to answer questionnaires unless explained to, 30 (23.8%) had secondary education and 36 (28.6%) had tertiary education including Diploma, Bachelors and Post Graduate degrees. The more educated respondents including workers and some refugees could avail proper response because they understood the crux of the research. This implies that the educated ones were able to read and interpret the questionnaire contents (questions) on their own with limited hurdles, so the researcher was able to maintain reliable data for the study which supports further analysis and interpretation.

**4.1.4. Period stayed or worked in the camp**

Experience determines the level of validity and reliability of research and therefore, the study asked respondents to state their period of stay at Bidibidi camp and the results are presented in Table 4.4

**Table44.4: Period stayed or worked in the camp (in years)**

|  |  |  |
| --- | --- | --- |
| Period in Years | Frequency | Percent |
| 0-5 | 36 | 28.6 |
| 6-10 | 78 | 61.9 |
| Valid  11 and above | 12 | 9.5 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

The findings in Table 4.4 revealed that 36 (28.6%) of the respondents has stayed or worked in the camp (in years) for 0 to 5 years, 78 (61.9%) had stayed and worked in the camp for 6 to 10 years, and 12 (9.5%) had stayed or worked in the camp for 11 years and above. Therefore, there have been varying periods of stay and work the camp (in years).

**4.2 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp**

Epidemiology is based on 5Ws which include stands not clear for diagnosis or health event, who which stands for person, which stands for place, which stands for time and why/how stands for causes, risk factors and modes of transmission. The study findings on the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp are presented, analyzed and interpreted in this section;

**4.2.1 Voluntary counseling and guidance services for HIV/AIDS for refugees**

The study tried to determine whether the level of education of the respondents was correlated with access to voluntary counseling and guidance for the refugees and Table 4.5 was generated.

**Table 4.5 Correlation analysis between level of education and accessibility of voluntary counseling and guidance services of refugees**

|  |  |  |
| --- | --- | --- |
| Variables | Level of  education | Accessibility  of  counseling  and  guidance  services |
| Correlation Coefficient | 1.000 | 0.426\*\* |
| Level of education Sig. (2-tailed) |  | 0.000 |
| Spearman’s rho N | 126 | 126 |
| Correlation Coefficient | 0.426\*\* | 1.000 |
| Accessibility of counseling and Sig. (2-tailed) | 0.000 |  |
| guidance services N | 126 | 126 |

The results shows that the level of education of the respondents is positively correlated with accessibility of counseling and guidance services for HIV/AIDS in Bidibidi refugee camp (P = 0.000). This means that the national medical staff at Bidi-Bidi health centre III and the various Non-Governmental Organizations’ medical staff, for example, the American refugee Committee and Norwegian refugee Council, United Nations High Commission for Refugees encourage the refugees to check and know their HIV/AIDS status. In addition to counseling, the HIV/AIDS patients are reportedly provided with free access to treatment (Anti-retroviral treatment) so that they can live longer. This is relates to UNAIDS (2011) which noted that HIV/AIDS infection is endemic in sub-Saharan Africa, which is home to just over 12% of the world’s population but two-thirds of all people infected with HIV/AIDS, and with this alarming numbers that there is need to ensure that the refugees are encouraged to take voluntary counseling and guidance services for HIV/AIDS in order to reduce the prevalence of this pandemic among the people, more so the refugees.

**4.2.2 There is diagnosis regarding the HIV/AIDS health status of the people**

Respondents were asked to state whether there is diagnosis regarding the HI V/AIDS health status

of the people and the results are presented in Table 4.6;

**Table54.6: There is diagnosis regarding the HIV/AIDS health status of the people**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 12 | 9.5 |
| Disagree | 24 | 19.0 |
| Valid Not sure | 30 | 23.8 |
| Agree | 42 | 33.3 |
| Strongly Agree | 18 | 14.3 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

As indicated in Table 4.6, 12(9.8%) of the respondents strongly disagreed, 24(19.0%) disagreed, 30(23.8%) were not sure, 42(33.3%) agreed and 18(14.3%) strongly agreed. Majority of the respondents that is 47.6% agreed that there is diagnosis regarding the HIV/AIDS health status of the people since after testing them, they have to find out whether one is positive or not so that they

can administer the safety measure and anti-retroviral treatment on them. On the other hand 23.8% were not sure and 28.5% disagreed noting that many refugees are not aware of their HIV/AIDS status because they have not tested since the refugee settlement has a big population of about 340,300 and the health services are often overwhelmed (Office of the Prime Minister, Disaster Management Report, 2018); but the government of Uganda and the international Non-Governmental Organizations such as American refugee Committee have supported health services including HIV/AIDS treatment for the refugees, thus diagnosis regarding the HIV/AIDS health status of the refugees in Bidi-Bidi refugee settlement is comprehensive and a right to undertake.

**4.2.3 There are medical facilities to provide HIV/AIDS services to the people**

Respondents were asked to state whether there are medical facilities to provide HIV/AIDS services to the people and the results are presented in Table 4.7.

**Table64.7: There are medical facilities to provide HIV/AIDS services to the people**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 3 | 2.4 |
| Disagree | 15 | 11.9 |
| Valid Not sure | 27 | 21.4 |
| Agree | 66 | 52.4 |
| Strongly Agree | 15 | 11.9 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

From the table 4.7, 3(2.4%) of the respondents strongly disagreed, 15(11.9%) disagreed, 9 (21.4%) were not sure. 66(52.4%) agreed and 15(11.9%) strongly agreed. From the findings, it is clear that with 64.3% in agreement, the data indicates that there is medical facility at Local Government level III, but the refugees are so many compared to services available.

Even with 14.3% in disagreement, the heath facility and those which have been established by the Non-Governmental Organizations and private persons who have supported testing for HIV/AIDS as well as Anti-Retroviral treatment; there has been further support with therapeutic feeding for children living with HIV/AIDS. In line with this presentation and analysis, Spiegel (2004) noted that the relationship between HIV/AIDS and forced migration is very complex and there is a multitude of factors that both increase and decrease refugees’ vulnerability, and this includes putting in place medical facilities which should support counseling and guidance as well as providing HIV/AIDS services’ treatment and management among the refugees. This would reduce the various factors that increase vulnerability to contracting and dying of HIV/AIDS by ensuring treatment, prevention and coping mechanisms.

**4.2.4 There is regular medical support for the HIV/AIDS positive refugee patients** Respondents were asked to state whether there is regular medical support for the HIV/AIDS positive refugee patients and the results are presented in Table 4.8.

**Table74.8: There is regular medical support for the HIV/AIDS positive refugee patients**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 12 | 9.5 |
| Disagree | 12 | 9.5 |
| Valid Not sure | 33 | 26.2 |
| Agree | 48 | 38.1 |
| Strongly Agree | 21 | 16.7 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

As indicated in Table 4.8, 12(9.5%) of the respondents strong disagreed, 12(9.5%) disagreed, 33(26.2%) were not sure, 48(38.1%) agreed and 21(16.7%) strongly agreed. With 54.8% in agreement, it indicates that the health facilities in and around the refugee settlement are able to provide testing and treatment for HIV/AIDS among the refugees who are positive at no cost or at a very minimal cost which enables them to succeed, and for 26.2% being not sure and 19.0% in disagreement means that refugee HI V/AIDS health services are not well developed, but there is regular medical support for the HIV/AIDS positive refugee patients with counseling and treatment through anti-retroviral services on daily and routine basis. In support of this line of argument, UNAIDS et al., (2005) the provision of health services supports refugees to take the necessary preventative measures to stop the spread of HIV/AIDS through promoting prevention and treatment efforts for the entire refugee community in Bidi-Bidi Refugee Settlement.

**4.2.5 The medical staff and counselors aim at creating awareness among the refugees about the occurrence and causes of HIV/AIDS**

Respondents were asked to state whether the medical staff and counselors aim at creating awareness among the refugees about the occurrence and causes of HIV/AIDS and the results are presented in Table 4.9;

**Table84.9: The medical staff and counselors aim at creating awareness among the refugees about the occurrence and causes of HIV/AIDS**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Disagree | 24 | 19.0 |
| Not sure | 21 | 16.7 |
| Valid Agree | 54 | 126.9 |
| Strongly Agree | 27 | 21.4 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

The majority of respondents according to table 4.9, 24(19.0%) of the respondents disagreed, 21(16.7%) were not sure, 54(126.9%) agreed and 27(21.4%) strongly agreed. With 64.3% in agreement, it means that the medical staff aim and counselors create awareness among the refugees about the causes of HIV/AIDS. On the other hand, 35.7% disagreed that there is very limited awareness creation as the refugees are often scattered and less bothered to take up HIV/AIDS services. But the medical staff aim and counselors create awareness among the refugees about the causes of HIV/AIDS through explaining to them the risk factors and how to prevent and fight the escalation of the infections.

The study further tried to determine the relationship between awareness about the occurrence and causes of HIV/AIDS and their level of education and the results in Table 4.10 were obtained.

|  |  |  |
| --- | --- | --- |
| Variables | Level of  Education | Awareness  about  Occurrence  of  HIV/AIDS |
| Correlation Coefficient | 1.000 | 0.556\*\* |
| Level of Education Sig. (2-tailed) |  | 0.000 |
| Spearman’s rho N | 126 | 126 |
| Correlation Coefficient | 0.556\* \* | 1.000 |
| Awareness about occurrence of HIV/AIDS Sig. (2-tailed) | 0.000 |  |
| N | 126 | 126 |

The results revealed that the level of education of the respondents is positively related to the awareness of the occurrence of HIV/AIDS among refugees (P = 0.000). Therefore, despite that the relationship between awareness and level of education is slightly more than half (55.6%), it has not helped the situation since the transmission of HIV/AIDS among refugees has not stopped.

In relation to the above findings, Spiegel (2004) noted that providing HIV/AIDS awareness and counseling services to refugees is an overwhelming task due to the difficulty of establishing services in complex emergencies as well as the multitude of factors that both increase and decrease refugees’ vulnerability; Uganda is obliged under international human rights law for providing equal and non-discriminatory access to existing health services to refugee in Bidi-Bidi refugee settlement, and in this endeavor, the Ugandan government is supported by humanitarian organizations from within and without such as the Norwegian refugee Council, Uganda Red Cross society and others. In addition, Spiegel (2004) stated that if refugees enter a country where the HIV prevalence is higher than that of their country of origin, their vulnerability is increased as they face greater exposure to HIV from the host population.

**4.2.6 The medical staff and counselors create awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS**

Respondents were asked to state whether the medical staff and counselors create awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS and the results are presented in Table 4.10;

**Table94.10: Medical staff and counselors create awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 1 | 2.4 |
| Disagree | 4 | 9.5 |
| Valid Not sure | 8 | 19.0 |
| Agree | 15 | 35.7 |
| Strongly Agree | 14 | 33.3 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

Table 4.10, 1(2.4%) of the respondents strongly disagreed, 4(9.5%) disagreed, 8(19.0%) were not

sure, 15(35.7%) agreed and 14(33%) strongly agreed. With 69.0% in agreement, it means that the medical staff at the Health Centre III and the various Medical Facilities have put in place various measures that aim to ensure proficiency of counseling that create awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS for example to avoid engaging in unprotected sex, falling for many sexual partners, drug and substance abuse and many others. For 11.9% in disagreement, it indicates that the medical staff and counselors have not been able to create thorough awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS. For Rhodes *et al.,* (2005), the occurrence of the vulnerability and risk environment including the socio-cultural condition which allow early engagement in sexual activities through early marriage and the sexual permitivee among the refugee, a well as the high poverty increase risk of refugee engaging in reckless sexual activities that expose them to HIV/Aid. At both the micro- and macro-level, the risk environment accounts for physical location, social and cultural norms, economic influences and applicable policy that combine to increase vulnerability to sexual hazards and in response, the medical staff and counselors have tried to create awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS .

**The Refugees vulnerability to HIV/AIDS in Refugee settlement camps**

The refugees are vulnerable to HIV/AIDS because they have not been able to change their

behaviours, engage in risky sexual behaviours and have not been able to test and obtain ant­retroviral treatment adequately in this Refugee Settlement Camp. The study findings on the refugee vulnerability to HIV/AIDS in Refugee settlement camp are presented, analyzed and interpreted below;

**4.3.1 The refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS**

The study findings no whether the refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS , and the results are presented in Table 4.11;

**Table104.11. Refugees are so much engaged in unprotected sexual intercourse which exposes**

Percent

|  |  |  |
| --- | --- | --- |
| Disagree | 12 | 9.5 |
| Not sure | 15 | 11.9 |
| Agree | 66 | 52.4 |
| Strongly Agree | 30 | 23.8 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

As presented in Table 4.11, 3(2.4%) of the respondents strongly disagreed, 4(9.5%) disagreed, 15(11.9%) were not sure, 66(52.4%) agreed and 10(23.8%) strongly agreed. With 76.2% of the respondents in agreement, it indicates that the refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS since they are redundant and for them sexual intercourse is acceptable as long as the girls and the boy have reached puberty. Even the older men take advantage of the vulnerable less astute and can hardly stop themselves getting engaged in sex, so event eh HIV/AIDS positive men and women take advantage of them which escalates the rate of HI V/AIDS infections. And for 11.9% were not sure and 11.9% disagreed that the refugee children are not loosely involved in sexual intercourse; though it is very common for the young people to get engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS in the area. In support of this fact, Spiegel, (2004) revealed that refugees are particularly vulnerable to HIV/AIDS , and addressing their medical needs is essential to carrying-out an effective public health effort against HIV/AIDS . This is because the available knowledge how that as a marginalized group, refugees are inherently more vulnerable to HIV/AIDS , which is exacerbated through the reckless engagement in unprotected sex due to loss of social stability and exposure to conflict. The vulnerable people are easy to manipulate for sex which exposes them to HIV/Aid, and the cycle is endless.

**4.3.2 The refugee children engage in sex at an early age which exposes them to contracting HIV/AIDS**

The study findings on whether the refugee children engage in sex at an early age which exposes them to contracting HIV/AIDS , and the results are presented in Table 4.12;

**Table114.12: Refugee children engage in sex at an early age which exposes them to contracting HI V/AIDS**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Disagree | 15 | 11.9 |
| Not sure | 21 | 16.7 |
| Valid Agree | 54 | 126.9 |
| Strongly Agree | 36 | 28.6 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

Results in Table 4.12, 15(11.9%) of the respondents disagreed, 21(16.7%) were not sure, 54(126.9%) agreed, 36(28.6%) strongly agreed; and with 7 1.5% of the respondents in agreement, it indicates that the refugee children engage in sex at an early age usually as long as one has reached at least 12 years and above. This exposes the children to contracting HIV/AIDS in the same vein. Furthermore, 16.7% were not sure, and 11.9% disagreed which implies that there is less knowledge on the prevalence of HIV/AIDS among the young children because many do not go for testing; but with perception and knowledge obtain from respondents in interviews, refugee children engagement in sex at an early age exposes them to the risk of contracting HIV/AIDS .

In support of this, UNAID (2005) opine that the refugee children are not knitted in a social fabric that bind them together, therefore in the refugee settlement, they can engage in a series of activities including ex which may be with people including men and women who have HIV/Aid, though the South Sudanese tend to have a culture which does not permit sexual pleasure until one I married, but the huge refugee mix-up in making it hard for them to observe the prohibitive norm. Thus the young people are exposed to the risk of HIV/Aid at an alarming rate in Bidi-Bidi Refugee settlement.

**4.3.3. HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS**

The study findings on whether treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS, and the results are presented in Table 4.14;

**Table134.14: Treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 12 | 9.5 |
| Disagree | 12 | 9.5 |
| Valid Not sure | 39 | 31.0 |
| Agree | 54 | 126.9 |
| Strongly Agree | 9 | 7.1 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

As indicated in Table 14, 12(9.5%) of the respondents strongly disagreed, 12(9.5%) disagreed, 39(31.0%) were not sure, 54(126.9%) agreed and 9(7.1%) strongly agreed. The findings of the study therefore show that 5 0.0% in agreement means that indeed the treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS and fail to get treatment for HIV/AIDS. For 3 1.0% were not sure and 19.0% in disagreement, it means that the treatment for HIV/AIDS is available but the people do not focus so much on accomplishing it. But indeed, the treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS. But UNAIDS *et al.,* (2005) agreed that there is treatment for HI V/AIDS in the area through voluntary counseling and testing, anti-retroviral treatment, prevention of mother to child transmission and post-exposure prophylaxis, but they are so inadequate and some one may find it hard to comprehend such services exist. Thus these services are not easily accessible to the refugees who make it hard for those living with HIV/AIDS to receive the necessary and adequate treatment and nutrition health support.

**4.3.5 There is no promotion of mother to child transmission which exposes the young newly born children to HIV/AIDS**

The study findings on whether there is no promotion of mother to child transmission which exposes

the young newly born children to HI V/AIDS, and the results are presented in Table 4.14;

**Table144.15: There is no promotion of mother to child transmission which exposes the young newly born children to HIV/AIDS**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 6 | 4.8 |
| Disagree | 12 | 9.5 |
| Valid Not sure | 24 | 19.0 |
| Agree | 66 | 52.4 |
| Strongly Agree | 18 | 14.3 |
| Total | 126 | 100.0 |

**Source: Primary data (2021)**

As presented in Table 15, 6(4.8%) of the respondents strongly disagreed, 12(9.5%) disagreed,

24(19.0%) were not sure, 22(52.4%) agreed and 6(14.3%) strongly agreed. With 66.7% of the respondents in agreement, it indicates that the health services are not well developed like their contemporaries in places such as Gulu, Arua, and Kampala or elsewhere in the cities in the country because the medical facilities, treatment and other medical requirements are not well provided, or the demand from refugees is overwhelming. Though 19.0% were not sure and 14.3% disagreed that the services are available but they are very inadequate yet the demand from a population of 304,300 is high. But the truth is that there is no promotion of mother to child transmission which exposes the young newly born children to HIV/AIDS. The PMCT service are available to all, but acceding them in refugee community is very hard since they are even very inadequate (Spiegel (2004); and this coupled with the high demand for them make it hard have them availed to the refugee in Bidi-Bidi refugee settlement since also the demand overwhelm their supply and availability.

From interviews in the field of study, the researcher discovered the other factor which lead to exposure of refugee to HIV/AIDS include the increased vulnerability which disrupts access to resources, and consequently impacting treatment, prevention efforts and coping mechanisms. There is loss of physical, financial and societal security; and as Spiegel (2014) noted, the increase of sexual violence is also common and exposing the refugees to HIV/AIDS primary and secondary infection. The study further discovered that behavioural changes deal with lack of income and instability which can occur including transactional sex or increasing drug use, which can greatly increase the spread of HIV/AIDS where necessary for preventative measures that are not taken care of.

**4.4 Policies addressing HIV/AIDS and Refugees and how HIV/AIDS related health care services are achieved in Bidibidi refugee settlement camp**

The study findings on the various policies addressing HIV/AIDS and Refugees and how HIV/AIDS related health care services are achieved in Bidibidi refugee settlement camp, range from international to national policies are presented, analyzed and interpreted below;

**4.4.1 Integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes**

The study findings on the integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes are presented in Table 4.16;

**Table154.16: Integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 3 | 2.4 |
| Disagree | 9 | 7.1 |
| Valid Not sure | 18 | 14.3 |
| Agree | 57 | 45.2 |
| Strongly Agree | 39 | 31.0 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

According to the table 4.16, 3(2.4%) of the respondents strongly disagreed, 9(7.1%) disagreed,

18(14.3%) were not sure, 57(45.2%) agreed and 39(31.0%) strongly agreed. With 76.2% in agreement, it indicates that the Uganda government and refugee support agencies at international levels and Non-Governmental Organizations have integrated their support efforts to provide testing services, anti-retroviral treatment, feeding and other nutrition needs to the children and adult persons living with HIV/AIDS in order to improve their health. This is in line with refugee health care national strategic plans and other HI V-related policies and programmes for better fight against HIV/AIDS. In Uganda, the UNHCR and UNAIDS (2011) recommend including and integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes. This best practice publication demonstrates the value of and need for this approach. It also reviews the circumstances that make a refugee’s situation unique, examines how the host country’s management of refugee situations affects host populations, and suggests what can be done to address the needs of refugees living with HI V/AIDS.

**4.4.2 HIV prevention activities in refugee camps should be ongoing**

The study findings on whether HIV prevention activities in refugee camps should be ongoing are presented in Table 4.17;

**Table164.17: HIV prevention activities in refugee camps should be ongoing**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 9 | 7.1 |
| Disagree | 48 | 38.1 |
| Valid Not sure | 27 | 21.4 |
| Agree | 27 | 21.4 |
| Strongly Agree | 15 | 11.9 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

According to table 4.17, 9(7.1%) of the respondents strongly disagreed, 48(38.1%) disagreed, 27(21.4%) were not sure, 27(21.4%) agrees and 15(11.9%) strongly agreed. With 33.3% in agreement, it means that HIV/AIDS prevention activities in refugee camps is quite ongoing because efforts are made to intensify existing programmes prior to the refugees return to their country of origin which is South Sudan. In particular, the HIV/AIDS repatriation packages which include information-education-communication materials in the appropriate languages like Madi, Lugbara, Arabic/Nubian, Kakwa and English are sued to help in awareness creation, and further condoms are being distributed, and appropriate HIV/AIDS training is being provided.

The UNAIDS (1995) publication on the protection mandate for refugees titled, “Policy Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)” reveals that refugees could not be expelled from a country based on their HIV status, but rather have to be provided with necessary anti-retroviral support and nutrition for health living without being stigmatized. But in Uganda, more so Bidi-Bidi refugee Settlement, the growing practice of testing refugees for HI V/AIDS, not mandatory but by encouragement is putting a huge burden on the Ugandan health budget and is not sustainable, though it is being done. To improve it further, the public in formation campaigns and more comprehensive education programmes are bring implemented in these areas before and during repatriation in order to reduce instances of general discrimination against returnees, as well as any HIV-related discrimination and misinformation are being fought through this information given to refugees returning to South Sudan.

**4.4.3 HIV prevention interventions should be expanded**

The study findings on whether HIV/AIDS prevention interventions should be expanded are presented in Table 4.18;

**Table174.18: HIV prevention interventions should be expanded**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 21 | 16.7 |
| Disagree | 33 | 26.2 |
| Valid Not sure | 45 | 35.7 |
| Agree | 18 | 14.3 |
| Strongly Agree | 9 | 7.1 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

According to table 4.1 8, 21(16.7%) of the respondents strongly disagreed, 33 (26.2%) disagreed, 45(35.7%) were not sure, 18(14.3%) agreed and 9(7.1%) strongly agreed. With 21.4% in agreement means that HIV prevention interventions ought to be expanded to include comprehensive programmes to prevent sexual violence, provision of post-exposure prophylaxis, more targeted information-education-communication materials for high risk groups for example counseling and guidance; reproductive health services for women and men and services for preventing mother-to-child transmission of HIV. However, this is not well developed, while 35.7%

were not sure and 26.9% disagreed because these programmes have not been well achieved, though contrary to this, but the calming care services are better informed through palliative and home-based support and care for people living with AIDS. For UNAIDS et al., (2005), the solution lies to provide means to prevent HIV/AIDS positive refugees from feeling vulnerable or isolated through this transitory phase, but have to be on-going all the time. These durable solutions requires that in order to prevent lack of health services and reduce discrimination due to their HIV status, refugees are not forced to undergo mandatory testing or disclose their HIV status, but are encouraged to undertake treatment services. Another issue is ensuring continued access to HIV/AIDS services for refugees once resettled or repatriated, which is good but not implemented, however, continuing ARV therapy is especially important since changes or lapses in this regime can significantly impact the medical progress of an individual’s life. For the refugees in Bidi-Bidi Refugee settlement, HIV/AIDS prevention interventions should be expanded to benefit all refugees infected and affected by the scourge in order to better their living conditions.

**4.4.4 The Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be set up**

The study findings on whether Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be set up are presented in Table 4.19;

**Table184.19: The Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be set up.**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 18 | 14.3 |
| Disagree | 27 | 21.4 |
| Valid Not sure | 15 | 11.9 |
| Agree | 48 | 38.1 |
| Strongly Agree | 18 | 14.3 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

From the table 4.19, 18(14.3%) of the respondents strongly disagreed 27(21.4%) disagreed,

15(11.9%) were not sure, 48(38.1%) agreed, and 18(14.3%) strongly agreed. With 52.4% in agreement implies that Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be set up including the Ministry of Health, Uganda Aids Commission and other agencies In-Charge of HIV/AIDS should be set up to improve HIV/AIDS response to the refugees.

UNAIDS (2005) revealed that HIV/AIDS emergence services through Inter-agency health support is available through establishing coordination mechanisms, providing access to basic health care for the most vulnerable people, providing a safe blood supply, adhering to universal precautions, providing basic HIV education materials, providing condoms at no cost, offering syndromic sexually transmitted infection treatment and ensuring safe material deliveries are available though inadequate. These efforts should include establishing coordination mechanisms, providing access to basic health care for the most vulnerable people, providing a safe blood supply, adhering to universal precautions, providing basic HIV education materials, providing condoms, offering syndromic sexually transmitted infection treatment, providing appropriate care for intravenous drug users, managing the consequences of sexual violence and ensuring safe maternal deliveries. These services will also provide the foundation for more comprehensive HIV interventions for example confidential voluntary counseling and testing and prevention of mother-to-child transmission, which should occur for better handling of HIV/AIDS among the refugees here in Bidi-Bidi or when they return home.

**4.4.5 Promoting refugee Self -Reliance Strategy**

The findings of the study on the promotion of refugee self-reliance strategy are presented in Table 4.20;

**Table194.20: Promoting refugee Self-Reliance Strategy**

|  |  |  |
| --- | --- | --- |
|  | **y**  Frequency | Percent |
| Strongly Disagree | 16 | 38.1 |
| Disagree | 12 | 28.6 |
| Valid Not sure | 8 | 19.0 |
| Agree | 2 | 4.8 |
| Strongly Agree | 4 | 9.5 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

As presented in Table 20, 48(38.1%) of the respondents strongly disagreed, 36(28.6%) disagreed, 24(19.0%) were not sure, 6(4.8%) agreed and 12(9.5%) strongly agreed. With 14.3% of the respondents in agreement, it means that the Ugandan government has sought the promotion of self reliance strategy so that refugees can engage in work for better productivity, and in 1998, the Government of Uganda, the Directorate of Refugees and UNHCR began discussions on

implementing the Self-Reliance Strategy.

Though for 19.0% were not sure and 66.7% in disagreement means that the Self-Reliance Strategy (established by the Office of the Prime Minister, 1998) does not work adequately as refugees have continued to be dependent on assistance for livelihoods. But the Strategy was developed to offset the burden placed on host country governments during protracted refugee situations. The overall goal is to improve the standard of living of the people in Bidi-Bidi Refugee Settlement for the including the refugees. The Strategy will accomplish this by improving food self-sufficiency, increasing access to social services such as health and education, and boosting local government capacity to plan and deliver essential services.

**4.4.6 Implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda**

The study findings on implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda are presented in Table 4.21;

**Table204.21: Implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 2 | 4.8 |
| Disagree | 1 | 2.4 |
| Valid Not sure | 6 | 14.3 |
| Agree | 17 | 40.5 |
| Strongly Agree | 16 | 38.1 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

Table 4.21 indicated that 6(4.8%) of the respondents strongly disagreed, 3(2.4%) disagreed,

18(14.3%) were not sure, 51(40.5%) agreed and 48(38.1%) strongly agreed. With 78.6% in agreement, it indicates that implementing the Uganda government is implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda which allow refugees to access services like the Ugandan nationals even in the field of employment seeking. On the contrary, 14.3% were not sure and 7.2% disagreed because the knowledge the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda are not well-known whether being implemented or not. The Uganda favourable protection environment for refugees is grounded in the 2006 Refugee Act and the 2010 Refugee Regulations legislations allow refugees freedom of movement, the right to work, establish a business, own property and access national services, including primary and secondary education and health care. South Sudanese refugees are granted refugee status on a prima facie basis, while refugees from other nationalities undergo Refugee Status Determination interviews with the Refugee Eligibility Committee, an inter-ministerial body. Prima facie refugee status determination for Burundian was revoked in May 2017 and entered into force on 1 June 2017.

**4.4.7 Promoting Settlement Transformative Agenda**

Respondents were asked to state whether promoting Settlement Transformative Agenda and the results are presented in Table 4.22;

**Table214.22: Promoting Settlement Transformative Agenda**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 15 | 11.9 |
| Disagree | 36 | 28.6 |
| Valid Not sure | 24 | 19.0 |
| Agree | 27 | 21.4 |
| Strongly Agree | 24 | 19.0 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

According to the table 4.22, 15(11.9%) of the respondents strongly disagreed, 36(28.6%)

disagreed, 24(19.0%) were not sure, 24(21.4%) agreed and 24(19.0%) strongly agreed. With 40.4% in agreement means that the Ugandan government thought he Office of the Prime Minister under the Settlement Transformative Agenda, pursues a non-encampment policy to refugee protection and assistance. Refugees are provided with a plot of land for housing and cultivation and can settle alongside their host communities. The CRRF seeks to advance Uganda’s Settlement Transformative Agenda, embedded into the National Development Plan II (NDP II, 2016-2021), including through the implementation of the humanitarian refugee response (emergencies and protracted situations) and development-oriented interventions like the Refugee and Host Populations Framework, under the United Nations Development Assistance Framework. CRFF’s long-term goal is sustainability of STA and inclusion of refugees into national and local development plans. A multi-stakeholder CRRF Steering Group, co-chaired by the Office of the Prime Minister and the Ministry of Local Government, supports the practical application of CRFF, with technical support from the CRRF Secretariat.

**4.4.8 Establishing voluntary counseling and testing (VCT) programmes**

The findings on whether establishing voluntary counseling and testing programmes, and the results are presented in Table 4.23;

**Table24.23: Establishing voluntary counseling and testing (VCT) programmes**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 21 | 16.7 |
| Disagree | 30 | 23.8 |
| Valid Not sure | 24 | 19.0 |
| Agree | 36 | 28.6 |
| Strongly Agree | 15 | 11.9 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

From the table 4.23, 21(19.7%) strongly disagreed, 30(23.8%) disagreed, 24(19.0%) were not sure, 36(28.6%) agreed and 15(11.9%) strongly agree. With 40.5% in agreement, it means that establishing voluntary counseling and testing programmes are well established in Bidi-Bidi Refugee camp. In Uganda, 19.0% of the respondents were not sure and 40.5% disagreed that the refugees have minimal access to voluntary counseling and testing services. Facilities are far from the settlements and outreach programmes have not been established. In support of this programme, in 2005 UNHCR and UNAIDS collaborated to develop specific strategies for countries like Uganda with South Sudanese refugees in Bidi-Bidi refugee settlement to adopt to help address the HIV/AIDS voluntary counseling and testing (VCT) programmes-related needs of refugee on a long-term basis, though it has worked but has not yet been effective. But because it is presented and is implemented despite the inadequacy in Bidi-Bidi, a strong link with the tuberculosis programme as part treatment for HIV/AIDS related symptoms has been established, and other refugee settings should adopt a similar approach. In Uganda, voluntary counseling and testing services must be established more comprehensively and strengthened in the few areas where they exist.

**4.4.9 Strengthening prevention of mother-to-child transmission**

The findings on whether strengthening prevention of mother-to-child transmission are presented in Table 4.24;

**Table234.24: Strengthening prevention of mother-to-child transmission**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 3 | 2.4 |
| Disagree | 12 | 9.5 |
| Valid Not sure | 15 | 11.9 |
| Agree | 72 | 57.1 |
| Strongly Agree | 24 | 19.0 |
| Total | 126 | 100.0 |

**Source: Primary data, 2022**

As indicated in Table 4.24, 3(2.4%) of the respondents strongly disagreed, 12(9.5%) disagreed, 72(57.1%) agreed and 24(19.0%) strongly agreed. With 76.1% in agreement, implies that the Ugandan government and refugee support agencies are enabling the strengthening, prevention of mother-to-child transmission expanded in a short period of time to Bidi-Bidi Refugee and other refugee camps. It is important to document the process and experiences in all refugee camps very

carefully, so strengthening of the monitoring and evaluation components is required. Though, 11.9% of the respondents were not sure and 11.9% disagreed, but attention should be paid to the counseling for feeding options of HI V/AIDS positive mothers and their children. In relation to the study, the Great Lakes Initiative on AIDS (1999) which has four main components: HIV/AIDS support to refugees, support to HIV-related networks, support to regional health-sector collaboration and a managing and evaluating sector some of which the chief ones is strengthening prevention of mother-to-child transmission, which is a good programme but the refugees do not use often and seriously, though it has worked for some refugees who care to focus on it during the antenatal and post natal services.

**4.4.10 Promoting home based care**

The finings on promoting home based care; the results are presented in Table 4.25; **Table244.25: Promoting home based care**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Disagree | 6 | 4.8 |
| Not sure | 12 | 9.5 |
| Valid Agree | 72 | 57.1 |
| Strongly Agree | 36 | 28.6 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

Results from table 4.25, 2(4.8%) of the respondents disagreed, 4(9.5%) were not sure, 24 (57.1%) agreed and 12 (28.6%) strongly agreed. With 85.7% in agreement, it means that the home based care programmes are being established in Bidi-Bidi refugee Camp. This would make it possible to treat opportunistic infections. The standardized protocols from the Ministry of Health or World Health organization (2012) are being adopted in Bidi-Bidi Refugee settlement programmes. Home based care programmes have been established in Bidi-Bidi Refugee settlement and many lessons have been learned and are being shared among the refugees. The introduction of anti-retroviral drugs in Bidi-Bidi Refugee settlement settings is a point.

**4.4.11 Support for the National AIDS Control Programme**

The findings of the study on support for the National AIDS Control Programme are presented in

Table 4.26;

**Table254.26: Support for the National AIDS Control Programme**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Strongly Disagree | 9 | 7.1 |
| Disagree | 6 | 4.8 |
| Valid Not sure | 18 | 14.3 |
| Agree | 72 | 57.1 |
| Strongly Agree | 21 | 16.7 |
| Total | 126 | 100.0 |

**Source: Primary data, 2021**

From table 4.26, 9(7.1%) of the respondents strongly disagreed, 6(4.8%) disagreed, 18(14.3%)

were not sure, 72(57.1%), 21(16.7%) strongly agreed. For 73.8% in agreement, it means that there is support for the National AIDS Control Programme through the Uganda Aids Commission and others. But for 14.3% were not sure, and 11.9% disagreed meaning that in Uganda, the international refugee agencies have not established sufficient links with the National AIDS Control Programme and other agencies for the inclusion of refugee settlements and the surrounding population in the yearly Ugandan surveillance.

Related to the study, like the Great Lakes Initiative on AIDS (GLIA, 2004) programme in Tanzania which is in place to integrate refugees into their national HIV/AIDS prevention programs, which is having important benefits in increasing prevention throughout the country, Uganda according to UNAIDS (2005) has in place a similar programme on stop AIDS, has begun to work with the Bidi-Bidi Red Cross Action team to support Living with HIV/AIDS. This coordination between a refugees and local population organizations works to provide HIV/AIDS awareness and education to both refugees and the surrounding communities. This initiative has been very successful in

organizing school activities, concerts, mass campaigns and public speakers, so as a result, not only is HIV/AIDS awareness increasing, but the cooperation of a local organization with a refugee organization, decreases the stigma surrounding the refugee population, so the National AIDS Control Programme in this case has performed well in fighting HIV/AIDS , though with just fair outcomes as it is not very popularly used as most refugees are so ignorant or do not care about such modern methods.

**CHAPTER FIVE  
SUMMARY, CONCLUSION AND RECOMMENDATIONS**

**5.0 Introduction**

This chapter contains the summary, conclusion and recommendations on South Sudanese refugees,

HIV/ AIDS and accessibility to medical care in Bidi-Bidi Refugee Settlement Camp in Northwestern Uganda. These are guided under the following objectives; To determine the epidemiology of HIV/AIDS in Bidibidi refugee settlement camp, assess the Refugees vulnerability to HIV/AIDS in Refugee settlement camps and identify policies and health care services on HIV/AIDS and Refugees in Bidibidi refugee settlement camp.

**5.1 Summary**

The following is the thematic summary of the findings;

**5.1.1 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp**

The study discovered that the national medical staff at Bidi-Bidi health centre III and the various

Non-Governmental Organizations’ medical staff for example American refugee Committee and Norwegian refugee Council, United Nations High Commission for Refugees encourage the refugees to check and know their HIV/AIDS status.

This was because the health centres and their coordinators whom they send to the refugee settlement help running counseling services and prepare the refugees for testing for HIV/AIDS. Refugees are provided with free access to treatment (Anti-retroviral treatment) so that they can live longer. Thus the government of Uganda and the international Non-Governmental Organizations such as American refugee Committee has supported health services including HI V/AIDS treatment for the refugees.

The health facilities in and around the refugee settlement are able to provide testing and treatment for HIV/AIDS among the refugees who are positive at no cost or at a very minimal cost which enables the exercise to succeed; there is regular medical support for the HIV/AIDS positive refugee patients with counseling and treatment through anti-retroviral services on daily and routine basis.

For 64.3% of the respondents, the medical staff aim and counselors create awareness among the refugees about the causes of HIV/AIDS among the refugees about the causes of HIV/AIDS through explaining to them the risk factors and how to prevent and fight the escalation of the infections.

Further 69.0% of respondents revealed that the medical staff at the Health Centre III and the various Medical Facilities has put in place various measures that aim to ensure proficiency of counseling, creation of awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS.

**5.1.2 The Refugees vulnerability to HIV/AIDS in Bidibidi Refugee settlement camps**

A total of 76.2% respondents agreed that the refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS since they are redundant and for them sexual intercourse is acceptable as long as the girls and the boy have reached puberty. In addition, 1.5% of respondents agreed that the refugee children engage in sex at an early age which exposes them to the risk of contracting HIV/AIDS.

The results of the study revealed that refugee awareness about HIV/AIDS is still quite limited which makes it easy for the young and adults to engage in activities that exposes them to contracting HIV/AIDS . Indeed the treatment for HIV/AIDS is still so limited in the area which exposes the victims to further spread of HIV/AIDS and fails to get treatment for HI V/AIDS; the treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HIV/AIDS. With 66.7% of the respondents in agreement, it indicates that the health services not well developed because the medical facilities, treatment and other medical requirement are not up to date, so there is no promotion of mother to child transmission which exposes the newly born children to HIV/AIDS.

**5.1.3 Policies addressing HIV/AIDS and Refugees health care services in Bidibidi refugee settlement camp**

According to the study, the refugee livelihoods are supported by the Uganda Government and refugee support agencies at international levels and Non-Governmental Organizations. This has been integrating their support efforts to provide testing services, anti-retroviral treatment, feeding and other nutrition needs to the children and adult persons living with HIV/AIDS in order to improve their health. Further more, integrating refugee health care into National Strategy programmes demonstrates the value of and need for this approach. The HIV/AIDS repatriation packages which include information-education-communication materials in the appropriate languages like Madi, Lugbara, Arabic/Nubian, Kakwa and English are sued to help in awareness creation, and further condoms are being distributed, and appropriate HIV/AIDS training is being provided. The public information campaigns and more comprehensive education programmes bring implemented in these areas before and during repatriation in order to reduce instances general discrimination against returnees.

**5.2 Conclusion**

The following is the thematic conclusion of the finding

**5.2.1 The epidemiology of HIV/AIDS in Bidibidi refugee settlement camp**

The study discovered that the Ugandan government and Non-Governmental Organizations’ medical staff encourage the refugees to undergo HIV/AIDS treatment by helping running counseling services and prepare the refugees for testing for HIV/AIDS, and also they are provided with free access to treatment (Anti-retroviral treatment) and feeding. So the health staff is supportive to the efforts to address HIV/AIDS among the refugees. The health facilities in and around the refugee settlement area able to provide testing and treatment for HIV/AIDS among the refugees who are positive at no cost or at a very minimal cost which enables them to succeed; there is regular medical support for the HIV/AIDS positive refugee patients with counseling and treatment through anti-retroviral services on daily and routine basis. Furthermore, there is creation of awareness among the refugees about the risk factors and modes of transmission of HIV/AIDS.

**5.2.2 The Refugees vulnerability to HIV/AIDS in Refugee settlement camps**

The study concludes that the refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS since they are redundant and for them sexual intercourse is acceptable as long as the girls and the boy have reached puberty. Many refugees engage in risky sexual behaviours at an early age and also recklessly which exposes them to the risk of contracting HIV/AIDS. The awareness about HIV/AIDS among the refugees is still limited which makes it easy for the young and adult to engage in activities that exposes them to contracting HIV/AIDS. And further, the PMCT and other transmission modes still threaten the very existence of the refugees’ lives.

**5.2.3 Policies addressing HIV/AIDS and Refugees related health care services are achieved in Bidibidi refugee settlement camp**

The study concludes that the refugee livelihoods are supported by the Uganda Government and refugee support agencies at international levels, and Non-Governmental Organizations have integrated their support efforts to provide testing services, anti-retroviral treatment, feeding and other nutrition needs to the children and adult persons living with HI V/AIDS in order to improve their health. And integrated refugee health care into National Strategic programmes demonstrates the value of and need for this approach. The Inter-agency Standing Committee guidelines on HIV/AIDS interventions would improve HIV/AIDS response to the refugees. The Ugandan government should emphasize the refugee Self-Reliance Strategy in order to improve the standard of living of the people in Bidi-Bidi Refugee Settlement. Appraising the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda would further foster the protection of refugees since it allows refugees freedom of movement, the right to work, establish a business, own property and access

national services, including primary and secondary education and health care, strengthen health support for refugees living with HIV/AIDS and their dependants as well as the entire refugee community in Bidi-Bidi Refugee camp.

**5.3 Recommendations**

Having accomplished the study on South Sudanese refugees, HIV/ AIDS and accessibility to medical care in Bidi-Bidi Refugee Settlement Camp in Northwestern Uganda, the following are the recommendations:

1. The Ugandan government refugee support programme should be involved in creating entry points for non-traditional refugee responders in Uganda, with the following priority focus; adaptation and standardization of refugee response and protection based on lessons learne.
2. The government of Uganda should also ensure access to quality education for refugee an host communities, support for water delivery and infrastructure, environment and energy development, promoting health care and livelihood programmes as well as resilience a self-reliance for refugees.
3. The Ministry of Education and Sports of Uganda should introduce the Education Respon Plan to carry out HIV/AIDS sensitization and awareness education in schools and th refugee settlements (s) and ensure that they are well developed in Bidi-Bidi refugee camp and other camps and settlements.
4. Continued attention should be paid to prevention programmes, thus universal precautio in health facilities, especially by organizing refresher training for staff working HIV/AIDS campaigns as well as including health professional’s interventions.
5. An Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be s up to include Ministry of Health, Uganda Aids Commission and other agencies. especia to improve HIV/AIDS response such as VCT, PMTCT to the refugees.
6. To support this further, in 1998, the Government of Uganda, the Directorate of Refuge and UNHCR began discussions on implementing the Self-Reliance Strategy whose goal is to improve the standard of living of the people (food, social services) in Bidi-Bidi Refugee Settlement for the including the refugees.

7) Refugee support activities are well defined under the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda although apparently not well-known. whether being implemented or not. The Refugee Act provides a favorable protection environment for refugees since it allows refugees freedom of movement, the right to work, establish a business, own property and access national services, including Home based programm have also been established in Bidibidi refugee settlement.

**5.4 Areas for further study**

Further studies can be carried out in the following fields:

1. Health Policy and Planning in the fight against HIV/AIDS among the refugee mothers in Uganda;
2. The contribution of existing health information systems in the fight against HIV/AIDS in local communities in Uganda
3. Health sector reforms and health service delivery among refugee communities in Uganda.

**REFERENCES**

Bailey, S. (2004). Is Legal Status Enough? Legal Status and Livelihood Obstacles for Urban Refugees. Boston: The Fletcher School.

Center for Disease Control and Prevention (2008).HIV/AIDS Fact Sheets. Retrieved January 29, 2009 from CDC Web site:http ://[www.cdc.gov/hiv/topics/basic/index.htm](http://www.cdc.gov/hiv/topics/basic/index.htm)

Craddock, S. (2000). Disease, social identity, and risk: rethinking the geography of AIDS. Transaction of the Institute of British Geographers.25, 153-168.

Dwyer-Lindgren, Laura; Cork, Michael A.; Sligar, Amber; Steuben, Krista M.; Wilson, Kate F.; Provost, Naomi R.; Mayala, Benjamin K.; VanderHeide, John D.; Collison, Michael L. (2019). "Mapping HIV prevalence in sub-Saharan Africa between 2000 and 2017"

Eidenier, E. (2005) “Providing Health Care Information to Refugees in Cairo: Questionsof Access and Integration. “Presented at the American University in Cairo HealthPanel on May 28, 2005.

Hewitt, K. (1997). Regions of Risk: A Geographical Introduction to Disasters. Harlow: Longman.

Kalipeni E,& Oppong J. (1998). The refugee crisis in Africa and implications for health and disease: a political ecology approach. Social Science & Medicine (1982).46 (12), 1637-53.

Kalipeni, E. (2004). HIV and AIDS in Africa: Beyond epidemiology. Malden, MA: Blackwell Pub.

Kalipeni, E. (2004). HIV and AIDS in Africa: Beyond epidemiology. Malden, MA: Blackwell Pub.

Mayer, J. D. (2005). The geographical understanding of HIV/AIDS in sub-Saharan Africa. Norweigan Journal of Geography.59 (1), 6-13.

Oppong, J. R. (1998). A Vulnerability Interpretation of the Geography of HIV/AIDS in Ghana, 1986-1995. Professional Geographer.50 (4), 437-448.

Organization of African Unity (1969).Convention Regarding Specific Aspects of the Refugee Status in Africa.

Rhodes T, &Simic M. (2005). Transition and the HIV risk environment. BMJ (Clinical Research Ed.).331 (7510), 220-3.

Spiegel, P (2004). HIV/AIDS Among Conflict=affected and Displaced Populations: Dispelling Myths and Taking Action. Disasters.28, 322-339.

Spiegel, P, &Nankoe, A (2004). UNHCR, HIV/AIDS and refugees: Lessons learned. Forced Migration Review. 19, 21-23.

Timberg, Craig (2007). "Speeding HIV's Deadly Spread". The Washington Post.ISSN 0190- 8286.(Retrieved 12 August 2017).

UNAIDS & UNHCR (2005). Strategies to support the HIV-related needs of refugees and host populations (UNAIDS Best Practice Collection). Geneva, Switzerland: UNAIDS.

UNAIDS (2003). A conceptual framework and basis for action: HIV/AIDS stigma and discrimination. Geneva, Switzerland: UNAIDS.

UNAIDS (2003).A conceptual framework and basis for action: HIV/AIDS stigma and discrimination. Geneva, Switzerland: UNAIDS.

UNAIDS (2005).AIDS epidemic update: December 2005. Geneva, Switzerland: UNAIDS.

UNHCR (1990).Policy Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS).Geneva, Switzerland: UNAIDS.

UNHCR (2007).Project Proposal: Enhancing access of refugees and persons of UNHCR concern living with HIV and AIDS to Anti-Retroviral Theory (ART) as part of a comprehensive VCT and PMTCT preventive care package. Cairo, Egypt:UNHCR.

UNHCR (2017) South Sudan Situation 2017 Supplementary Appeal. Available at: <http://www.unhcr.org/593e9e9b7.pdf>

UNHCR. (2008). UNHCR Statistical Yearbook: Trends in Displacement, Protection and Solutions. Geneva, Switzerland: UNHCR.

United Nationals (1967).Protocol Relating to the Status of Refugees.

UNMISS (2017) A report on violations and abuses of international human rights law and violations of international humanitarian law in the context of the fighting in Juba, South Sudan. Available at: [http://www.ohchr.org/Documents/Countries/SS/ReportJuba16Jan20 1](http://www.ohchr.org/Documents/Countries/SS/ReportJuba16Jan20%201) 7.pdf.

Watts, M. J., & Bohle, H. G. (1993). The space of vulnerability: the casual structure of hunger. PROGRESS IN HUMAN GEOGRAPHY.17 (1), 43.

WFP (2017) WFP South Sudan Situation Report #201 (November, 2017)

Wisner, B., Blaikie P., Cannon T., & I. Davis. (2004). At Risk: Natural hazards, people’s vulnerability and disasters. London: Routeledge.

World Health Organization. (2008). Epidemiological Fact Sheets on HIV and AIDS, 2008 update: Core data on epidemiology and response. Geneva, Switzerland: WHO.

Zvi Bentwich, Alexander Kalinkovich, Ziva Weisman, (1995), Immune activation is a dominant factor in the pathogenesis of African AIDS Copyright 1995 Published by Elsevier Ltd. <https://doi.org/10>. 1016/0167-5699(95)80119-7;

**APPENDICES  
Appendix 1: Questionnaire Guide**



**NKUMBA UNIVERSITY**

**SCHOOL OF SCIENCES**

**DATE: JANUARY 2022**

I am Tandia, a student of Nkumba University undertaking a research study on South Sudanese Refugees, HIV/ AIDS and accessibility to medical in Bidibidi Refugee Settlement Camp, Northwestern Uganda.

The purpose of this questionnaire is to obtain information for academic purposes only, so feel free to avail responses because your identity will not be revealed and the information you give shall be sued for this research alone.

Yours,

………………………………………….

**Tandia (Researcher)**

**SECTION A: Respondents’ personal variables**

1. Gender :

Male ( ) Female ( )

1. Age :

15-30 years ( ) 3 1-45 years ( ) 46 years and above ( )

1. Education level:

Below Primary and Primary level ( ) Secondary ( ) Tertiary ( )

1. Period stayed or worked in the camp (in years) : 0-5 years ( ) 6-10 years ( ) 11 years and above ( )

***For section B, C and D use the scale below: Strongly Disagree (SD=1), Disagree (D=2), Not sure (NS=3), Agree (A=4) and Strongly Agree (SA=5)***

**SECTION B: The epidemiology of HIV/AIDS in Bidi-Bidi Refugee Settlement Camp**

1. The refugees are encouraged to take voluntary counseling and guidance services for HIV/AIDS Strongly Disagree ( ) Dis agree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. There is diagnosis regarding the HIV/AIDS health status of the people

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree

Strongly Agree ( )

1. There are medical facilities to provide HIV/AIDS services to the people

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. There is regular medical support for the HIV/AIDS positive refugee patients

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. The medical staff aim and counselors create awareness among the refugees about the causes of HI V/AID S

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. The medical staff and counselors create awareness among the refugees about the risk factors and modes of transmission of HI V/AIDS

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

**SECTION C: The Refugees vulnerability to HIV/AIDS in Refugee settlement camps**

1. The refugees are so much engaged in unprotected sexual intercourse which exposes them to contracting HIV/AIDS

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree

Strongly Agree ( )

1. The refugee children engage in sex at an early age which exposes them to contracting HIV/AIDS

|  |  |
| --- | --- |
| Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree  Strongly Agree ( )  3) The refugee awareness about HIV/AIDS is still limited which makes it easy for HI V/AID S  Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree  Strongly Agree ( ) | contracting |

1. Treatment for HIV/AIDS is still so limited in the area which exposes the victims to further contract HI V/AIDS

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. There is no promotion of mother to child transmission which exposes the young newly born children to HI V/AIDS

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

**SECTION D: Policies addressing HIV/AIDS and Refugees and how HIV/AIDS related health care services are achieved in Bidi-Bidi refugee settlement camp**

1) Integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. HIV prevention activities in refugee camps should be ongoing

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. HIV prevention interventions should be expanded

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. The Inter-agency Standing Committee guidelines on HIV/AIDS interventions should be set up Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. Promoting refugee Self-Reliance Strategy

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. Implementing the 2006 Refugee Act and the 2010 Refugee Regulations of Uganda Strongly Disagree ( ) Disagree ( )Not sure ( ) Agree ( )

Strongly Agree ( )

1. Promoting Settlement Transformative Agenda

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. Establishing voluntary counselling and testing (VCT) programmes

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( )

9) Strengthening prevention of mother-to-child transmission

Strongly Disagree ( ) Disagree

( ) Not sure ( ) Agree ( )

( ) Not sure ( ) Agree ( )

Strongly Agree ( )

1. Promoting home based care

Strongly Disagree ( ) Disagree

Strongly Agree ( )

1. Support for the National AIDS Control Programme

Strongly Disagree ( ) Disagree ( ) Not sure ( ) Agree ( )

Strongly Agree ( ) **End**

**Appendix 2: Interview guide**



**NKUMBA UNIVERSITY**

**SCHOOL OF SCIENCES**

**DATE: JANUARY 2022**

I am **Mary William Khamis Tandia,** a student of Nkumba University undertaking a research study on South Sudanese Refugees, HIV/ AIDS and accessibility to medical in Bidibidi Refugee Settlement Camp, Northwestern Uganda.

The purpose of this interview guide is to obtain information for academic purposes only, so feel free to avail responses because your identity will not be revealed and the information you give shall be sued for this research alone.

Yours,

………………………………………….

Tandia (Researcher)

**Section A: The epidemiology of HIV/AIDS in Bidibidi Refugee Settlement Camp**

1. How does government support the fight against HIV/AIDS among the refugees?
2. In what ways is voluntary counseling and guidance carried out?
3. How is diagnosis for HIV/AIDS carried out?
4. In what ways is HIV/AIDS awareness created among the refugees in the camp?

**Section B: The Refugees vulnerability to HIV/AIDS in Refugee settlement camps** 1) In what ways is HIV/AIDS commonly spread among the refugees?

2) In what ways is mother to child transmission being neglected and leading to increase in HIV/AIDS infections?

**Section C: Policies addressing HIV/AIDS and Refugees and how HIV/AIDS related health care services are achieved in Bidibidi refugee settlement camp**

1. In what ways can HIV/AIDS be addressed among the refugees?
2. In what ways is government of Uganda ensuring HIV prevention activities in the refugee camp are ongoing?
3. In what ways are refugees being helped to survive?
4. Any other informa

**Appendix: III. Observation checklist**

1. Treatment process at the health center
2. Existence of medical staff in the refugee settlement camp
3. Dispensation of medical items at the health center
4. Health infrastructure in the refugee settlement camp
5. Sanitation environment in refugee settlement camp

**Appendix III-Krejcie and Morgan table for sample determination**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **N S** | | **N S** | | **N S** | | **N S** | | **N S** | |
| 10 | 10 | 100 | 80 | 280 | 162 | 800 | 260 | 2800 | 338 |
| 15 | 14 | 110 | 86 | 290 | 165 | 850 | 265 | 3000 | 341 |
| 20 | 19 | 120 | 92 | 300 | 169 | 900 | 269 | 3500 | 346 |
| 25 | 24 | 130 | 97 | 320 | 175 | 950 | 274 | 4000 | 351 |
| 30 | 28 | 140 | 103 | 340 | 181 | 1000 | 278 | 4500 | 351 |
| 35 | 32 | 150 | 108 | 360 | 186 | 1100 | 285 | 5000 | 357 |
| 40 | 36 | 160 | 113 | 380 | 191 | 1200 | 291 | 6000 | 36I |
| 45 | 40 | 180 | 118 | 400 | 196 | 1300 | 297 | 7000 | 364 |
| 50 | 44 | 190 | 123 | 420 | 201 | 1400 | 302 | 8000 | 367 |
| 55 | 48 | 200 | 127 | 440 | 205 | 1500 | 306 | 9000 | 368 |
| 60 | 52 | 210 | 132 | 460 | 210 | 1600 | 310 | 10,000 | 373 |
| 65 | 56 | 220 | 136 | 480 | 214 | 1700 | 313 | 15,000 | 375 |
| 70 | 59 | 230 | 140 | 500 | 217 | 1800 | 317 | 20,000 | 377 |
| 75 | 63 | 240 | 144 | 550 | 225 | 1900 | 320 | 30,000 | 379 |
| 80 | 66 | 250 | 148 | 600 | 234 | 2000 | 322 | 40,000 | 380 |
| 85 | 70 | 260 | 152 | 650 | 244 | 2200 | 327 | 50,000 | 381 |
| 90 | 73 | 270 | 155 | 700 | 248 | 2400 | 331 | 75,000 | 382 |
| 95 | 76 | 270 | 159 | 750 | 256 | 2600 | 335 | 100000 | 384 |

NOTE: N=Total Population Size  
S= Sample Size  
***Source: Krejcie& Morgan, 1970***