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HIV/AIDS and Income Generation: The Use of Microfinance Initiatives as a Prevention Strategy in Sub-Saharan African Refugee Camps

I. INTRODUCTION

In an address before the Social, Humanitarian and Cultural Committee of the United Nations (UN) General Assembly on November 1, 2011, the head of the United Nations High Commissioner for Refugees (UNHCR), António Guterres, declared that the twenty-first century is "proving to be a century of people on the move" (United Nations, "21st Century"). The number of displaced people worldwide reached 43.7 million in 2010, the highest level in over a decade. Approximately 15.4 million of these displaced people were legally considered refugees, having crossed international borders, "owing to a well-founded fear of being persecuted" (United Nations, *Global* 2; United Nations, "Convention" 14). The global refugee crisis has been of particular concern for the nations of Sub-Saharan Africa, which hosted 2.2 million refugees in 2010, nearly one-fifth of the total number of refugees aided by UNHCR (United Nations, *Global* 11). In addition to the increasing numbers of displaced persons in recent years, UNHCR has also noted an increase in the prevalence of protracted refugee crises, situations in which at least 25,000 refugees have been displaced for five or more years (United Nations, "Protracted" 2). In 2004, sixty-one percent of refugee situations were considered protracted, as opposed to forty-three percent in 1992 (United Nations, *The State of the World's Refugees 2006* 109). As of 2006, the nations of Sub-Saharan Africa were home to seventeen protracted refugee situations, the

highest number in the world, involving 1.9 million people (United Nations, *The State of the World's Refugees 2006* 109).

Following the identification of Human Immunodeficiency Virus (HIV) in 1984, the prevention and treatment of HIV and Acquired Immune Deficiency Syndrome (AIDS) has become of increasing importance to the work of UNHCR and partner non-governmental organizations (NGOs) in refugee contexts, particularly in Sub-Saharan Africa, where an estimated 22.5 million people were living with AIDS in 2009 (United Nations, *UNAIDS Report* 20). Protracted refugee situations, characterized by a lack of basic rights and decreasing levels of humanitarian aid, have posed particular difficulties for the development and implementation of effective HIV prevention measures. This paper will provide an overview of the factors that increase the susceptibility of refugees in protracted situations to HIV transmission as well as prevention responses by the UN and partner NGOs in Sub-Saharan Africa. Through the examination of HIV/AIDS prevention programs in Nyarugusu Refugee Camp in Tanzania, this paper will highlight certain weaknesses of the current education-based methods of HIV prevention promoted by UNHCR and argue that these measures are inadequate in reducing risk behaviors and population susceptibility, while successful examples of microfinance initiatives, such as the programs managed by American Refugee Committee in Guinea, effectively address the underlying social and environmental factors which increase susceptibility to HIV. This paper will contend that, when implemented in conjunction with the current UNHCR prevention methods, microfinance and other income generation initiatives can reduce the susceptibility of protracted refugee populations to HIV transmission.

II. REFUGEES POPULATIONS AND SUSCEPTIBILITY TO HIV

The unique characteristics of protracted refugee situations create an environment in which residents of refugee camps are highly susceptible to the spread of HIV. In particular, the rearrangement of social networks as a result of displacement, the increasing prevalence of sexual violence used as a weapon of war in Sub-Saharan Africa and the lack of economic opportunities in refugee camps increase the practice of risk behaviors, thereby creating a high level of susceptibility to HIV transmission.

A. Displacement

Displacement itself may have a role in encouraging risk behaviors by spurring the rearrangement of sexual networks and social norms (Von Roenne et al.; Wallace). Due to the nature of protracted conflicts, refugees are forced to reside outside of their home country for years or even decades, often separated from family members, spouses, and their communities. Refugees also face the possibility of being transferred to another refugee camp or resettled in a third country. As Anna Von Roenne et al. note in a review of reproductive health services in Guinea, "Years of conflict and disruption in the refugees' countries of origin have resulted in forced separation from long-term sexual partners and have led to the development of new socially acceptable sexual practices and attitudes towards women. With constant resettlement of individual refugees, multiple sexual partners may have become the norm" (76). Even if the pre-conflict society discouraged these behaviors, the displacement of populations during and after conflict may lead to the practice of certain risk behaviors, such as having multiple sexual partners, which increases susceptibility to HIV transmission.

B. Rape and Sexual Violence Perpetrated by Armed Groups

In addition to the rearrangement of social networks due to displacement, the use of rape and sexual violence by armed groups against civilian populations increases the susceptibility of refugee populations to HIV transmission before and during their stay in refugee camps. As HIV can only be spread through blood, semen, vaginal fluid and breast-milk, abrasions and cuts, such as those commonly sustained from violent or forced sex, facilitate HIV transmission through blood or semen by "allow[ing] the virus to more easily cross genital mucosa" (United Nations, *Behavioral* 6). Rape and sexual violence may also spread sexually transmitted diseases (STDs), which facilitate the transmission of HIV by increasing the likelihood of infected blood-to-blood or blood-to-fluid contact through broken skin or membranes (Barnett 42).

The use of rape and sexual violence by armed forces as weapons of war has been increasing in recent decades, and has been observed in conflicts in Liberia, Rwanda, the Democratic Republic of Congo, and Sierra Leone (Elbe). As studies have found that HIV and STD prevalence rates are two to five times higher among military groups in Sub-Saharan Africa than among civilian populations, men and women raped by military forces face a much higher risk of HIV infection, either as a direct result of the rape, or indirectly as a result of STDs contracted during the rape (Khaw 183; Elbe 163). For example, a 2004 report by Human Rights Watch found that seventy percent of the 250,000 women survivors of the Rwandan genocide who were raped are now HIV-positive (qtd. in Mukherjee 117). This number is significantly higher than the national HIV prevalence rate in Rwanda, which was estimated to be 2.9% in 2009 (United Nations, "Rwanda Statistics"). These statistics demonstrate the elevated risk of HIV transmission faced by survivors of rape or sexual violence.

The threat of rape and sexual violence does not disappear once displaced persons reach the assumed safety of refugee camps. Even in protracted refugee situations, rapes may continue

to be perpetrated against refugees in and around the camps. For example, female residents of the world's largest refugee camp, Dadaab Refugee Camp in Kenya, reported 358 incidents of sexual and gender-based violence between January and June of 2011 ("Sexual Assault"). Many of these occurred in the bush around the camp when women left to collect firewood or use the latrines ("Sexual Assault"). The layout of Dadaab is similar to that of many other refugee camps, in that latrines, water pumps, and other essential services are placed near the insecure peripheries of the camp, leaving the women and children who access them vulnerable to attack (Benjamin; Hankins 2250). Since rape and sexual violence continue to occur in and around refugee camps, even in protracted situations, refugees face an elevated susceptibility of HIV transmission

C. Lack of economic opportunities

In addition to the possibility of HIV transmission through rape and sexual violence perpetrated by armed groups, the lack of economic opportunities in refugee camps creates a structurally violent environment that facilitates increased sexual violence and transactional sex, behaviors that amplify the risk of HIV transmission. Due to restrictions placed on refugees by host countries, refugee camps are frequently characterized by a lack of economic opportunities, violating the basic human right to work and creating a structurally violent environment which systematically excludes refugees from "the resources needed to fulfill their full human potential" (Mukherjee 115). In some cases, host countries limit the ability of camp residents to travel and work outside the camps, reducing access to employment and resources. The Kenyan government, for example, restricts the 400,000 residents of Dadaab from leaving the camp except to collect firewood (Sommers 186). Furthermore, the three camps that make up Dadaab are located in a resource-poor semi-arid area of eastern Kenya and farming is prohibited inside the camp,

eliminating the possibility of agricultural work for camp residents (Sommers 186). As a result, camp residents have few opportunities to make money, and must survive on the rationed supplies provided by UNHCR and other humanitarian agencies.

The lack of economic opportunities in refugee camps increases the susceptibility of refugee populations to HIV by decreasing the ability of male refugees to fulfill cultural expectations of economic power and a socially recognized manhood, which in turn may provoke rape and gender-based violence. The cultural construction of masculinity in Sub-Saharan Africa places a high value on achieving financial independence, being able to physically, economically, and socially protect women and children and having a high sex drive (Barker; Bujra; Jaji; Meger). Without the ability to work and provide for their wives and children, men are unable to fulfill these cultural requirements and achieve a socially recognized manhood, effectively "demasculating" these male refugees (Barker 29). This "economic 'impotence' places masculinity in a crisis" that results in an attempted reassertion of male dominance, in some cases through violence and sexual assault (Jaji 84). A participant in a 2006 South African focus group noted this connection between unemployment and violence: "For me it's the power problem you know, men want to be seen as 'I am the man in charge', and secondly for me it's the problem of unemployment that results in men abusing women" (Strebel et al. 519). Another woman in the same study added, "It's because men lack self-esteem or confidence, so they have to, it's like they are nothing, they come and use their power in the household, to their wife, to their children" (Strebel et al. 519). The frustration felt by men due to the lack of economic opportunities in refugee camps results in increased instances of gender-based violence, affecting both married and single women. As noted above, violence can further increase the likelihood of HIV transmission by creating cuts and abrasions which facilitate the mixing of infected body fluids.

Therefore, the lack of economic opportunities in refugee camps directly affects the susceptibility of refugee populations to HIV transmission.

Economic difficulties also encourage risk behaviors that raise the susceptibility of refugee populations (particularly female refugees) to HIV transmission by increasing the necessity of transactional sex. In times of conflict, sex becomes a form of currency, traded in exchange for food, money, protection, or other material goods (Barnett 129; Benjamin; Hankins 2246; Khaw 184; Von Roenne et al. 16). The economic needs created by the lack of financial opportunities in refugee camps forces some refugee women to engage in risky sexual behaviors, such as transactional sex, in order to survive. As a South African man confirmed in a 2006 focus group,

> HIV will not decrease, instead it will increase, because of what? Because of poverty. People tell themselves 'I'm hungry here at home, let me go and sell myself in order to come back here and eat'. So the girl looks and sees 'hey this man is right, he will provide me with breakfast'. It's not that this girl wants to do it, she is doing it because of hunger. (qtd. in Strebel et al. 525)

As women are forced to engage in transactional sex in order to survive, the lack of economic opportunities in refugee camps creates a structurally violent environment that raises the susceptibility of refugees in general, and particularly of female refugees, to the transmission of HIV.

The unequal distribution of power inherent in these sexual transactions is compounded by existing cultural norms that place women in subservient societal roles, further decreasing the personal agency of refugee women. Without a sense of agency, defined by Joia S. Mukherjee as

"the ability to say 'no' and have it be heard," it is difficult to negotiate safe sex practices, including the use of condoms (117). A 35-year-old Congolese refugee woman interviewed in 2007 explained that "men have knowledge about and the power regarding condom use, but women have neither. We cannot refuse sex without condoms. … The decision to use condoms remains that of men, and women are far from being about to have a say" (Tanaka et al. 443). As this woman's testimony shows, women in Sub-Saharan Africa have little agency in negotiating condom use. This lack of negotiating ability stems partly from cultural norms which place women in subservient roles, and partly from the economic vulnerability of women, which forces them to engage in risk behaviors in order to survive. In these situations, the lack of economic opportunities in refugee camps is tied directly to risk behaviors (such as not using condoms during intercourse and having multiple partners), which in turn increases susceptibility to HIV transmission.

III. HIV/AIDS PREVENTION RESPONSE IN REFUGEE CONTEXTS

Having established the susceptibility of refugees to HIV transmission as a result of displacement, incidences of rape and sexual violence and the lack of economic opportunities in refugee camps, we can now turn to an examination of existing interventions. In recent years, UNHCR and partner NGOs have designed guidelines to combat HIV/AIDS in refugee settings. These guidelines focus heavily on providing access to treatment and services for those affected by HIV. In the area of HIV prevention, the guidelines promote education-based tactics to encourage behavior changes and decrease the practice of risk behaviors. However, as this paper will show through an examination of prevention programs in Nyarugusu Refugee Camp in Tanzania, the effectiveness of these prevention methods is undermined by certain factors present in refugee

contexts. This section will provide an overview of specific aspects of the UNHCR guidelines for HIV prevention as well as an analysis of the effective application of these methods in Nyarugusu.

A. UN Guidelines

Finding a response to the spread of HIV/AIDS first became a priority of both governmental and non-governmental humanitarian groups following the 1994 Rwandan genocide, which resulted in the displacement of two million Rwandans to Zaire, Tanzania, Burundi and Uganda (United Nations, *The State of the World's Refugees 2000* 246). In the years leading up to the genocide, Rwanda was estimated to have a national HIV prevalence rate of 2.0%, although rates were found to be as high as 17.8% in some urban areas (Kayirangwa et al.). As a 1997 UNAIDS report reflected, "Never before had there been an emergency of such proportions in a country with such a high prevalence of HIV. It quickly became clear that responding to the epidemic could not be delayed until stability was restored" (United Nations, *Refugees* 3). In response to this new threat, UNHCR and partner NGOs began to reexamine crisis response guidelines and integrate HIV prevention tactics into these processes.

In 2010, the HIV Task Force of the U.N.'s Inter-Agency Standing Committee (IASC) issued the *Guidelines for Addressing HIV in Humanitarian Settings*, a guide outlining HIV prevention practices in situations of humanitarian crisis, drawing on the experiences of governments, the UN, NGOs, the Red Cross Red Crescent movement, and other actors in the field. The *Guidelines* include sets of Minimum Initial Responses and Expanded Responses that NGOs and international agencies should follow in crisis situations in order to prevent the spread of HIV. The Minimum Initial Responses are separated into nine key sectors: HIV awareness

raising and community support; health; protection; food security, nutrition, and livelihood support; education; shelter; camp coordination and camp management; water, sanitation and hygiene; and HIV in the workplace (United Nations, *Guidelines* 8). As the majority of these guidelines focus on a medical response to HIV/AIDS, such as ensuring a non-infected blood supply and providing access to anti-retroviral treatments for HIV-positive camp residents, this paper will focus specifically on the non-medical Minimum Initial Responses described in the sectors "HIV Awareness Raising and Community Support", "Protection", "Food security, Nutrition and Livelihood Support", and "Education". While the other sectors addressed in the *Guidelines* are equally important to the development of a comprehensive response to HIV, these four sectors are most relevant to the focus of this paper.

The "HIV Awareness Raising and Community Support" sector of the *Guidelines* has the stated goal of helping to "raise awareness on information about rights and where to access HIV prevention and treatment services, and to empower communities to provide needed support" (United Nations, *Guidelines* 15). The Minimum Initial Response identified by the *Guidelines* consists of establishing an "awareness and community support team" and disseminating "existing messages and materials, using appropriate channels" (15). Specifically, the *Guidelines* note, it is important to include community members in the efforts, including women and people living with HIV if possible, and to ensure that disseminated messages and materials on HIV prevention and access to services are "culturally appropriate and field-tested" (15). The exigency that materials be culturally appropriate is of particular importance, as discussing sex is a cultural taboo in many Sub-Saharan African societies, raising the possibility of cultural clashes around the issue of HIV education.

The "Protection" sector of the *Guidelines* discusses the need for humanitarian groups to protect the affected population from "rape and sexual exploitation as well as other forms of violence" (41). As noted in earlier sections of this paper, rape and sexual violence increase susceptibility to HIV transmission; therefore it is important for NGOs and international agencies to work to minimize the prevalence of sexual violence in crisis situations. The Minimum Initial Reponses for the "Protection" sector include the development of a "coordinated response for the prevention of and response to gender-based violence" through the establishment of a working group, coordinated situation analyses, and the assurance that HIV issues are identified and addressed in the community response to gender-based violence (41). The *Guidelines* also encourage the development of programs addressing gender-based violence in collaboration with community and local leaders and the provision of information about health and psychosocial resources to survivors of gender-based violence (41). While these initiatives may be partially effective in encouraging dialogue around the topic of gender roles and gender-based violence, they do not address the underlying factors that drive violence. In particular, the *Guidelines* do not deal with the economic instability and frustrations that lead to elevated rates of violence in refugee settings, thereby lowering the effectiveness of the "Protection" measures.

The "Food Security, Nutrition and Livelihood Support" sector of the *Guidelines* includes a number of initiatives intended to "make people, especially women and children, less vulnerable to HIV infection" and decrease dependency on food assistance (43). In particular, the Minimum Initial Responses instruct humanitarian groups to work with existing community-based organizations that are involved with HIV-affected populations, map the needs of identified vulnerable households, and distribute appropriate food assistance to these families (43). Groups are also encouraged to integrate food assistance programs and HIV projects, and tailor food

programs to meet the needs of HIV-positive persons. For example, food distribution points should be located closer to residential areas, in order to minimize the need for ill people to carry their food long distances, and food assistance should give preference to milled cereals and other foodstuffs that are easy to prepare, due to the fact that chronically ill people require food to be made more frequently than healthy people (43). The *Guidelines* also support the introduction of dietary diversification, agricultural, and labor-saving programs in order to "protect/adapt the livelihoods of HIV-affected households and support homestead food production" (44). While these measures are beneficial for people already infected with HIV and their families, the *Guidelines* do not address livelihood aid for those who have not yet been infected. Therefore, these measures do little to prevent the spread of HIV to non-infected populations, as they do not effectively address the underlying factors that contribute to susceptibility and risk behaviors.

In the "Education" section, the *Guidelines* stress the responsibility of humanitarian groups to provide access to free and quality education (49). One of the most important sections is the Minimum Initial Response outlining the provision of "needs- and outcomes-based participatory life-skills-based HIV education" (49). These education programs are "directed towards knowledge, attitudes and skills with regard to identified risk behaviors", and focus on reducing vulnerability ("gender-based and sociocultural drivers of HIV infection, stigma and gender-based violence"), encouraging reduction of risk behaviors (including injecting drug use and unsafe sex), and increasing opportunities such as "health promotion, social and emotional learning for connectedness and vocational training for entrepreneurship" (49). This behavior-focused approach to HIV prevention is most often summed up by the acronym ABC, which stands for "Abstinence, Be faithful, and Condom usage". However, due to the economic and social realities of life in refugee camps, abstinence and fidelity may not be realistic options for

camp residents. In addition, as discussed earlier, the negotiation of condom use may not be possible in situations of female marginalization. As a result, these ABC-based programs fail to address the economic and social elements that inhibit adherence to traditional prevention methods.

B. Case study of HIV prevention programs in Nyarugusu Refugee Camp

While the *Guidelines for Addressing HIV in Humanitarian Situations* provide the foundation of the HIV prevention and response programs implemented by UNHCR and partner NGOs, each refugee situation presents a unique set of characteristics and challenges that result in prevention programs taking different forms in each context. This section will examine the implementation of HIV prevention programs in Nyarugusu Refugee Camp in Tanzania, summarize the risk factors in this context, and provide an analysis of the effectiveness of HIV/AIDS prevention programs in reducing susceptibility to HIV. The prevention programs will be judged on their success in educating camp residents about HIV/AIDS and in their ability to encourage condom usage among camp residents.

Nyarugusu Refugee Camp is located in the Kigoma region of western Tanzania, and is home to approximately 60,000 refugees, mostly from the Democratic Republic of Congo and Burundi (United Nations, *HIV/AIDS* 15-16). Founded in 1996 by UNHCR to accommodate the flood of Congolese refugees fleeing the First Congo War, Nyarugusu has since evolved into a long-term camp, with 72.1% of residents staying for seven years or more (Tanaka et al. 438). Records from voluntary counseling and testing (VCT) centers analyzed in 2009 found an HIV prevalence rate of 1.1% among adults, similar to that of the surrounding region (United Nations, *HIV/AIDS* 13). The HIV/AIDS prevention and treatment programs in Nyarugusu are coordinated

by UNHCR and two partner NGOs, the Tanzania Red Cross Society (TRCS) and World Vision (United Nations, *HIV/AIDS* 17). Programs in the camp include VCT services, free access to antiretroviral therapy (ART), home-based care for people living with AIDS, voluntary reproductive education, condom distribution, a peer education program for youth, and a Health Information Team (HIT). The peer education program reaches out to young people aged 10-24 years and uses lectures, puppet shows, community theater productions, posters, and meetings to promote safe sex practices and educate the camp's youth about HIV. The HIT is composed of camp residents with a background in medicine, and they work to play "a bridging role between all the refugee community and the encamped health services" by providing simple treatments, distributing condoms, and conducting home visits (Tanaka et al. 436). These outreach programs are supplemented by HIV prevention messages that are broadcast on Tanzanian radio stations every hour during the daytime (448).

A survey conducted by Yasuo Tanaka et al. in 2007 found that awareness of HIV/AIDS was high among residents of Nyarugusu, indicating the effectiveness of awareness-raising programs in the camp. Over ninety percent of men and women had heard of HIV/AIDS, although only 89.1% of men and 47.0% of women knew that HIV could be prevented through the use of condoms during every sexual encounter (Tanaka et al. 440). In the study, Tanaka et al. found that "radio broadcast messages", "dispensary/health posts" and "refugee workers" were the main source of HIV/AIDS information for camp residents (448-449). These findings indicate that the current HIV/AIDS programs in Nyarugusu, particularly the Tanzanian radio broadcasts, the VCT centers, the peer educators, and the HIT, are effective in raising the level of awareness of HIV/AIDS, although slightly less successful in communicating prevention techniques.

However, while knowledge of HIV was relatively high among residents of Nyarugusu, the practice of prevention strategies was significantly lower: only 17.5% of men and 9.6% of women had used a condom with their last non-regular partner (Tanaka et al. 441). A study conducted three years later by UNHCR found that the rate of condom usage with non-regular partners had increased only slightly, to 34.4% of men and 29.3% of women; however, these rates remain far below the targeted level of condom usage (United Nations, *HIV/AIDS* 85). The consistently low rate of condom usage indicates a failure of current prevention programs to successfully encourage safe sex practices.

One of the factors identified by Tanaka et al. and UNHCR that poses a problem to the effectiveness of HIV/AIDS prevention programs in Nyarugusu is the widespread practice of transactional sex. As discussed earlier in this paper, transactional sex is driven by economic necessity and is characterized by an unequal distribution of power. Like many other refugee camps, Nyarugusu is marked by an absence of economic opportunities. Seventy percent of respondents reported in 2007 that they had no income generating activities, and in 2010 only 15.0% of men and 4.2% of women reported earning a regular wage (Tanaka et al. 438; United Nations, *HIV/AIDS* 66). This lack of economic opportunities, when combined with the difficulty of living on rationed food portions, has resulted in elevated levels of transactional sex. Some 21.8% of respondents in Tanaka et al.'s survey said that they had engaged in sex in exchange for money or gifts following displacement. Compounding the riskiness of having multiple sexual partners is the fact that the rates of condom usage with transactional partners remained low (19.0% for men and 11.7% for women) (United Nations, *HIV/AIDS* 70). As one participant in a focus group explained in 2007,

> People don't eat well and don't dress properly. Some of us women in this camp, particularly during the period of Ndenga (when the food rations from aid agencies run out and before the next distribution arrives), cannot help but leave our husbands inside the house and go out to perform sex in order to obtain food. These women don't know whether their casual partners are HIV-infected of not, and when they come home could be directly contaminating their husbands. (Tanaka et al. 438)

As these testimonies and statistics demonstrate, economic necessity, directly tied to small food rations and a lack of economic opportunities in refugee camps, contributes to the practice of transactional sex, a risk behavior that increases the chance of HIV transmission. The immediate need for food or clothing outweighs considerations of long-term sexual health and effectively undermines the behavior change messages promoted by the current HIV/AIDS prevention programs.

The case study of Nyarugusu refugee camp reveals certain factors that undercut the effectiveness of current approaches to HIV/AIDS prevention in refugee camps. In particular, this example demonstrates the economic poverty that drives the practice of transactional sex and creates a structurally violent environment in which refugees are unable to care for their long-term health due to short-term struggles for survival. This is an issue which is not adequately addressed through current UNHCR approaches to HIV prevention, but which is critical to understanding the perpetuation of risk behaviors in refugee camps.

V. MICROFINANCE INITIATIVES IN REFUGEE CAMPS

Having ascertained the strengths and weaknesses of current UNHCR approaches to HIV/AIDS prevention in refugee camps, we can now examine a new trend in humanitarian relief: microfinance initiatives. This section will provide a brief introduction and history to microfinance in conflict situations, discuss one model of microfinance intervention developed by American Refugee Committee, and summarize the benefits of successful microfinance initiatives.

A. Introduction, History, and Context-Specific Challenges

UNHCR and the International Labor Organization (ILO) define microfinance as "the provision of financial services in a sustainable way to micro-entrepreneurs or any people with low incomes who do not have access to commercial financial services" (qtd. in Azorbo 2). Although the first experiments with microfinance took place during the 1970s, the Grameen Bank, founded in Bangladesh by Nobel Prize winner Muhammad Yunus in 1983, provided one of the first successful models of microcredit and spurred global experimentation with similar initiatives. By the 1990s, a coherent aggregate of microfinance practices was emerging, and best practice guidelines were being developed (Azorbo 2). Today, microfinance initiatives can take many forms, including loans, microinsurance, and savings programs. By lending small sums of money to potential entrepreneurs in impoverished areas, microfinance allows communities to build local economies, increase capital, and decrease poverty levels.

UNHCR first became interested in using microfinance in conflict situations during the 1990s, and has taken steps over the last decade to improve and expand microfinance activities, owing to the fact that microfinance initiatives "provide for a more dignified way of assisting displaced populations as they do not promote a culture of handouts but instead promise to

alleviate poverty through income generation" (Azorbo 1). This alternative form of poverty alleviation breaks with the traditional model of humanitarian assistance and, while not a panacea, may have important implications for future interventions, particularly when implemented in protracted refugee situations.

Microfinance initiatives in refugee camps face certain context-specific challenges that must be taken into account when developing potential programs (Azorbo 4). First, the mobility of the populations and the constant possibility of displacement or repatriation may threaten the repayment of loans and decrease the willingness of refugees to invest in long-term projects (5). Second, depending on the demographics of the refugee population, many individuals may be illiterate or have very low levels of education, hindering the effective construction of small businesses (4). Third, the restrictions placed on the movement, economic activities, and market access of camp populations may pose a problem to establishing or expanding a business (4). In order to be effective in protracted refugee situations, the organizations funding and managing microfinance interventions must acknowledge these challenges and adapt their programs to fit the context. One such organization that has successfully adapted to the refugee context and implemented microfinance programs is the American Refugee Committee (ARC).

B. American Refugee Committee (ARC) in Guinea

Through the 1990s and early 2000s, ARC, an international non-profit organization, managed microfinance initiatives in two Guinean refugee camps, Lainé and Kola, which served displaced Liberian refugees until the beginning of a voluntary repatriation plan in 2004. Begun in 1997, ARC's microfinance programs had served over 20,000 refugees by 2004 (De Klerk).

ARC's microfinance programs utilized a three-stage process to offer grants, loans, and business training to camp residents. At each stage, ARC's business training allowed camp residents to become progressively more self-sufficient, an essential characteristic of a successful microenterprise initiative. The first step of the program was a start-up grant of $25, used by the most impoverished clients to quickly establish a micro-business and gain an income. ARC decided that only women were eligible for these start-up grants "since they were the most vulnerable, especially the large percentage of female-headed households" (De Klerk). The second stage of the program consisted of an introduction to micro-credit services in the form of an interest-free $50 loan, to be repaid over six months. This stage was open to both men and women, although women still comprised eighty percent of the recipients (De Klerk). Once the $50 loan was repaid, clients moved to the third stage of the program, which was an advanced loan of $75 that bore minimal interest and allowed clients to expand their businesses (De Klerk). By March 2004, Kola Camp had a loan repayment rate of 70% and Lainé Camp had a loan repayment rate of 90%. After ARC reduced and refocused their activities in Kola Camp, the repayment rate increased to 94% by July 2004 (De Klerk).

One of the most innovative aspects of ARC's microfinance model was the Refuge to Return (R2R) program. This strategy effectively demonstrated the required adaptability of microfinance institutions and addressed one of the challenges of implementing microfinance in refugee camps; that is, the threat of repatriation as a deterrent to repayment of loans. ARC's R2R program established ARC microenterprise branches in Sierra Leone and Liberia, in the regions in which former camp residents were resettled. This method allowed clients to continue borrowing and expanding or reestablishing businesses after their repatriation and, "by holding out the prospect of further loans once clients have returned home, ARC provided an effective means to

induce clients to repay existing loans" (De Klerk). The R2R proved to be highly financially successful as well: three years after its founding, the program in Sierra Leone had reached over 7,000 people and had an active portfolio of $430,000 (De Klerk). While not every implementing NGO will have the financial or logistical ability to create a similar program, ARC's R2R program offers a unique and innovative model for a durable and effective microfinance intervention.

C. The Benefits of Microfinance Initiatives in Refugee Camps

While certainly not a panacea for poverty in refugee camps, successful microfinance initiatives have been proven to have beneficial effects on the financial and personal security of refugees in protracted situations. First, increased levels of income results in greater food and economic security for refugees. In a survey completed during a 2004 evaluation of ARC's programs in Guinea, 45% of loan clients said that they had more food, 33% stated that they were healthier, and 24% reported having a better variety of food (De Klerk). Higher incomes also allow greater access to healthcare and education for refugee families (Azorbo 7). The material goods and access provided by higher incomes have an important impact on the health and future prospects of refugee populations.

In addition to quantifiable economic benefits, the benefits of income and economic autonomy that stem from microfinance initiatives have positive impacts on personal security and empowerment. In the 2004 survey of ARC's programs, 55% of respondents stated that their social status had increased, 47% reported that they were more self-reliant, and 60% said that they had gained pride (De Klerk). By empowering clients to make business decisions and take control of their income, microfinance initiatives can encourage positive qualitative trends of

empowerment, self-esteem, and autonomy. This is particularly significant when one examines the effect of empowerment on women, whose societal roles are traditionally subservient. Microfinance initiatives can increase the personal and economic security of marginalized populations, transforming poor societies and creating possibilities for the future.

VI. AN INTEGRATION OF MICROFINANCE AND HIV/AIDS PREVENTION

While UNHCR and other humanitarian agencies have established programs on both HIV/AIDS prevention and microfinance, these initiatives are currently implemented simultaneously yet separately. However, an integration of these two disciplines could amend certain failures of the current approaches to HIV/AIDS prevention. While microfinance initiatives should not supplant traditional methods of education-based HIV prevention, microfinance initiatives can supplement these programs by successfully addressing the underlying factors that increase the susceptibility of refugees to HIV transmission.

As demonstrated by the case study of Nyarugusu Refugee Camp, one of the factors that increases the susceptibility of refugees to HIV transmission is economic poverty. The immediate needs of food, adequate shelter, and clothing, and the inability of refugees to attain these items through conventional means, result in some refugee women sacrificing their long-term health and engaging in transactional sex. By providing a source of income, microfinance initiatives can effectively decrease the need for transactional sex relationships, thereby reducing risk behavior and preventing the spread of HIV. Furthermore, by providing a means of income, microfinance initiatives can help male refugees mitigate their economic frustrations and move towards a socially accepted construction of manhood. This in turn can lower rates of sexual violence against women, another method of reducing HIV transmissions. By increasing the economic

standing of refugees, microfinance addresses the fundamental drivers of risk behaviors, succeeding where traditional methods of HIV prevention have failed.

In addition to addressing the economic needs of refugees, the sense of empowerment gained through microfinance programs can increase the social standing and sense of agency of marginalized refugee women. In gaining a sense of agency, women are more likely to negotiate condom use and other safe sex practices, proven prevention strategies that decrease the likelihood of HIV infection. By empowering women and increasing agency, microfinance initiatives can reduce risk behaviors and decrease the susceptibility of refugees to HIV transmission.

An integration of microfinance and income generation projects with traditional methods of HIV prevention offers an effective strategy to address the root causes of population susceptibility. Without an acknowledgement of the forces that drive risk behaviors, particularly economic poverty, current methods of HIV prevention will continue to be only marginally successful. UNHCR and other humanitarian agencies should examine the possibility of integrating microfinance practices into HIV prevention responses and vice versa, in order to better reduce the susceptibility of refugees to the spread of HIV. In particular, UN agencies should collaborate to improve microfinance practices in refugee camps, and humanitarian response guidelines should be edited to include the implementation of microfinance or other forms of income generating initiatives in HIV prevention methods. It is only by addressing the true foundations of population susceptibility that humanitarian agencies can begin to reduce the burden of risk on refugee populations and successfully combat the spread of HIV/AIDS in Sub-Saharan Africa.

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