

## HIV and emergencies: One size does not fit all

Context is critical for tailored responses

**T**he global HIV epidemic may have stabilised, and the number of new infections has fallen slightly since 2001. But there is no room for complacency. In 2007, 33 million people were living with HIV, and two million people died as a result of AIDS-related illnesses. Sub-Saharan Africa continues to bear the brunt of the global epidemic, accounting for more than two-thirds (68%) of all adults and 90% of all children with HIV (UNAIDS, 2008). In many regions, high levels of HIV infection coincide with humanitarian emergencies. In 2006, 1.8 million people living with HIV were also affected by conflict, disaster or displacement – 5.4% of all HIV positive people.

HIV and AIDS pose multi-sectoral challenges in good times – challenges that can undermine progress on poverty reduction and economic growth. These are exacerbated by humanitarian crises that may increase in severity in the face of climate change and economic crisis. It could be that the challenges of HIV will, increasingly, be located in fragile states or areas.

An increased understanding of what kinds of HIV prevention, treatment and care and support programmes and policies work in different emergency contexts is vital. If HIV-related vulnerabilities are not considered in emergencies, commitments made to ensure Universal Access to HIV prevention, treatment, care and support by 2010 are unlikely to be reached.

The dynamics and impact of HIV in humanitarian crises are complex. They depend on the kind of crisis: is it the result of conflict, a rapid-onset natural disaster (such as a flood or cyclone), or a slow-onset emergency caused by drought or environmental degradation? It also depends on the HIV prevalence rate before the crisis, the political situation, the scale and duration of the crisis, the existing infrastructure and services and the level of awareness of HIV.



**Haiti: uprooted from their homes by a cyclone, people gather at an emergency shelter.**

Despite growing awareness of the risks, HIV in emergencies is often addressed as one set of issues, with one set of responses. To highlight the vast range of effects and impacts, depending on the context, UNAIDS and the World Food Programme (WFP) asked ODI to develop a framework and typology to provide more detailed information and guidance for humanitarian responses on HIV in different types of emergencies.

Case studies from five countries facing very different emergencies and HIV prevalence rates (Box 1), were backed by a literature review. The countries represent three, often overlapping, types of emergency: conflict, rapid onset and slow onset. We examined the impact of emergencies on three areas: the risk of HIV transmission; people's ability to cope; and the effects on health-related services (Samuels et al., 2008).

### Emergencies and the risk of HIV

It is important to explore how (and if) emergencies increase vulnerability to HIV infection and how this varies from one emergency to another. In each case, knowing the context is crucial to

### Key points

- Humanitarian crises often increase the risk of HIV infection
- Efforts towards Universal Access can only succeed if HIV prevention, care and treatment are included in emergency programmes
- Responses to HIV in emergencies require understanding of specific contexts, and how they affect people's vulnerability and ability to cope

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### Box 1: Country case study contexts

Sri Lanka has an HIV prevalence of less than 0.1% and has a strong health service, with universal access to free health care. The tsunami of 26 December, 2004, was the largest and most destructive natural disaster in the country's history.

Central African Republic (CAR) has an HIV prevalence rate of 6.2%. Over the past 12 years, CAR has been affected by repeated bouts of armed conflict.

Central Turkana, Northern Kenya, has an HIV prevalence rate of 6.7% and is one of Kenya's least developed areas, with poor infrastructure, social marginalisation, drought, flash floods, high levels of food insecurity, malnutrition and an increasingly mobile population.

Haiti has an HIV prevalence rate of 2.2%, the highest in the Western Hemisphere and the highest rate outside Africa. It has suffered multiple overlapping crises relating to political instability and conflict and natural disasters.

Mozambique has an HIV prevalence rate of 12.5% and one of the highest and fastest-growing HIV epidemics in the world. While recovering from earlier decades of conflict, almost half of its people are affected by drought and flooding.

... understanding the extent to which this can lead to new HIV infections. Sexual and gender-based violence often increases during and after conflicts. In Haiti, rape increased during the conflict and political unrest from already high levels. A 23-year old woman said: *'that's what happens here, you just have to accept it, they will organise themselves, they will take out a knife, so you can't do anything about it. It can be several men, even 10 ... Victims will come to the hospital but will come late, as it is shameful to be raped.'* Similar stories are told in other conflict-affected countries.

While rape increases the risk of an individual woman contracting HIV, a recent review of HIV prevalence in seven conflict-affected countries in sub-Saharan Africa (Spiegel et al., 2007) found insufficient evidence that displacement and wide-scale rape increased HIV prevalence across an entire population. The Haiti case study bore this out: sexual violence and conflict do not mean increased prevalence. Here, prevalence remains relatively low, and fell between 2003 and 2005, though this could reflect changes in measurement methodology. This is not to belittle the trauma of rape, or the long-term impact on victims. But more research is needed on the factors that lead to a significant increase in HIV prevalence, such as the kind of HIV epidemic, levels of mobility and interaction between groups. Increased understanding could lead to more appropriate policies and programmes, such as increased access to post-rape counselling and post-exposure prophylaxis (PEP).

The use of sex as a survival strategy and bargaining tool is well known in conflicts, particularly where people are forced from their homes. Women may be forced to engage in sex to secure their livelihood or that of their family, or in return for safe passage, food, shelter or other resources. In the Central African Republic (CAR), researchers found commercial sex work becoming more common. The deteriorating economy pushes young women and girls into patterns of sex work that expose them to HIV infection. Commercial sex workers find themselves competing

for fewer clients and, with condoms unavailable and higher payment on offer for unprotected sex, the risk of HIV infection also increases. There is, therefore, evidence of greater risk of contracting HIV during conflicts because of the general breakdown in services and livelihoods, which leads to more transactional sex, rather than increased sexual violence *per se*.

During rapid-onset disasters, destitution, displacement and loss of income expose populations, particularly women and girls, to the risk of sexual exploitation to meet their most basic needs. However, in the Haiti and Mozambique case studies, there was no evidence that sexual or gender-based violence was a major problem in evacuation shelters or had increased as a result of natural disasters. But consensual sex, and 'transactional' sex increased. In Sri Lanka the term 'tsunami babies' was coined to indicate an increase in sexual activity. More sexual relationships can lead to greater risk of HIV transmission, particularly where condoms are not available.

Existing sex work patterns changed in response to rapid-onset natural disasters. In Mozambique, more sex workers arrived from outside the affected area, attracted by the growing number of humanitarian workers and transporters, such as truck drivers. In tsunami-affected Sri Lanka, there were reports of sex work declining in some areas and increasing in others, depending on the location and the amount of time that had elapsed since the tsunami. In Sri Lanka (Box 1), with a low HIV-prevalence rate, relatively low HIV awareness and high levels of stigma (Samuels et al., 2008), the ways in which sex work affects new infections is complex. While high levels of stigma and low awareness may stop people going for HIV-testing, low prevalence could reduce the risks of infection. Again, context is vital.

In slow-onset emergencies, such as those in northern Kenya and southern Mozambique, the effects of drought have pushed many young women into sex work for survival, also putting them at risk of HIV infection. New entrants into commercial sex work and those already working are increasingly vulnerable as, with more competition for clients, they are less likely to use condoms. *'If we miss clients, then that is a drought to us ...,'* said a sex worker in Kenya. *'but during droughts we have few clients and getting money is difficult, so condom use is unlikely. When many clients are available we use condoms ... if somebody refuses to put one on you are assured of getting another client.'* With fewer local clients available, women sex workers in Turkana move to the main highways and peri-urban settlements to find truck driver clients. Once again, HIV is a risk in a context where different high-risk groups come together in areas of high HIV prevalence and in a situation in which prolonged drought has exhausted traditional coping mechanisms.

### Resilience and coping

How do people cope in emergencies? And how does this coping affect the risks of HIV infection? People

living with HIV are often less able to cope and may remain in a ‘micro-emergency’, while HIV-negative people manage to pull themselves out of trouble. Networks of families, friends and neighbours (social capital) are key to coping in an emergency. In Haiti, people reported staying with neighbours and relatives, but this is a short-term solution, as it puts pressure on their hosts. For those with HIV, this coping strategy is often threatened by stigma, undermining their resilience and ability to recover.

One way in which people cope, especially during conflicts and slow-onset natural disasters, is to cut back on food consumption levels and dietary diversity, relying on drought-resistant or wild foods, or going for long periods without any food. In CAR, for example, the quality and quantity of people’s diets had been affected by the conflict, with people eating mainly tubers, and few cereals or meat. This means that people who are already weak, with compromised immune systems, become even weaker and less able to resume livelihood activities.

As we have seen, it is common for women to resort to transactional sex as a coping strategy in all emergency contexts.

A common coping strategy in all kinds of emergencies is fleeing conflict areas and, therefore, uprooting families. In response to insecurity in CAR, for example, people seek refuge in remote rural areas, in neighbouring towns or even in neighbouring countries. In such situations, people may have little or no access to health and other services.

In rapid-onset natural disasters, such as those in Haiti, Mozambique and Sri Lanka, many people, including those living with HIV, take shelter in schools, churches, and unused hospitals, but these temporary shelters may be unable to provide adequate food, water or sanitation. Again, such a coping strategy may increase the likelihood of the spread of disease, which, in turn, has a greater impact on those already weakened by HIV.

Many countries face repeated cyclones and storms (e.g. Haiti) and ‘on and off’ conflicts. People have to flee from their homes time and again, with each upheaval reducing their ability to withstand shocks, stress and trauma. Ultimately, all of their coping mechanisms could fail. It appears more difficult for those living with HIV to recover in any type of emergency, and this may be particularly the case in slow-onset natural disasters. The longer the emergency lasts, the harder it is for them to regain their health and their assets. At the same time, they face the stigma associated with being HIV positive. In northern Kenya in particular, the research shows that they were unable to re-engage in economic activities, as they lacked the necessary assets, well-being and supportive social networks.

## Health-related services

In conflicts, the reluctance of health staff to be posted to danger zones, and the difficulties patients face in reaching health providers, makes access to services

very problematic. Research in various countries, including CAR and Haiti, shows that access to health services during and after conflicts is limited, including: access to condoms and family planning services; treatment of sexually-transmitted infections (STIs); access to medicines; and access to post-rape care such as post-exposure prophylaxis (PEP).

Conflict-affected communities were, until a few years ago, excluded from international discourse on, and funding for, AIDS care and treatment. This stemmed from a perception that access to antiretroviral treatment (ART) requires a stable health infrastructure – often lacking in politically unstable countries. Refugees, however, often live for years in relatively stable settings in their host countries. Even in less stable settings, the increase in a person’s resistance to ART through stopping and starting therapy is seen by many as no more of a risk for conflict-affected populations than for other populations. This has been borne out by the work of Médecins sans Frontières in the Democratic Republic of Congo. The Haiti case study also confirms that ART is possible during conflict and political violence: the main hospital providing ART closed for only a few days during the violence and had stringent contingency plans to ensure that access to ART was not disrupted.

When it comes to rapid-onset natural disasters, research in Mozambique and Haiti found that flooding itself had little impact on health service provision. In Mozambique, most health care during the 2006 flooding was provided by existing local health facilities, and condoms were available in health centres after an initial shortage. The disruption to the level of care for people living with HIV was minimal, as the level was already low in most communities. Those people who were already on ART lived near the district centre, where HIV treatment is focused, and were not displaced. The few displaced people on ART were able to continue treatment through the efforts of health workers and activists.

In Sri Lanka, the tsunami washed away stocks of drugs and medical equipment, damaged infrastructure and affected health care personnel, but the provision of general health services continued, thanks to a health service that was well-established before the emergency. In this low-prevalence setting, very few people on ART were affected by the tsunami and it was possible to continue their treatment without any disruption. A review of the impact of the tsunami on people living with HIV in Indonesia, Sri Lanka, Thailand and India found that most of those interviewed first became aware of their HIV status as a result of the emergency health services provided after the tsunami (ANP+, 2007).

In recent decades, southern and eastern Africa has been vulnerable to drought and resulting food shortages and famines. The scale of the HIV epidemic in this region has exacerbated the impact of these problems. Countries face critical national-level inequalities in access to health and other basic services, with rural areas often the most neglected and the hardest hit by



slow-onset emergencies. The longer-term concerns surrounding HIV and AIDS may not be the priority for countries with an immediate life-threatening drought, although the linkages are clearly established.

### Policy next steps

*Contingency planning options need to be identified in all situations to ensure continued supply and access to ART, especially in areas suffering repeated natural disasters.* Emergencies do not disrupt ART supplies as much as feared, thanks to strong contingency planning by treatment providers, and the initiative of those on ART. However, there are relatively few people on ART in emergency settings, as not all of those who need ART receive it. If the number of people on ART increases as a result of efforts towards Universal Access to HIV prevention, treatment and care and support, the logistical challenges may increase and default rates may rise. Emergency preparedness should integrate the various issues around ART continuation, and existing contingency plans need to be reviewed in terms of their potential for going to scale in different contexts.

*Access to food assistance for people on ART needs to be assured in all emergency situations.* Even when ART supplies continue, adherence to treatment can be disrupted by other problems linked to emergencies, especially lack of food. In rapid-onset disasters, short-term food assistance arrives quickly, but this is more rarely the case in droughts, where it is often too little, too late and poorly targeted. Similar problems occur in some conflict settings. Debates around social protection are relevant, but also need to focus on how to target people with HIV in emergency situations.

*Access to free condoms is vital in all kinds of emergencies.* A recurrent finding was a lack of condoms. However, this often reflected the situation before the emergency. In some cases, the emergency meant more free condoms, which were distributed by aid agencies. Case studies confirmed the importance of condoms in rapid-onset natural disasters, where consensual sex in shelters increased. People in shelters often receive hygiene or cooking kits that could include condoms. Advocacy and awareness-raising on the importance of free condoms needs to be stepped up.

*The importance of transactional sex as a way of 'coping' has been underestimated and needs more policy attention.* The growth of transactional sex, combined with the influx of groups such as truck drivers, humanitarian workers and military personnel, can increase the risk of HIV transmission, especially

where condoms are unavailable. Ways to counteract this coping strategy need to be explored through livelihood recovery policies and programming, such as timely, targeted micro-credit schemes, as well as more HIV prevention campaigns for high-risk groups.

*Anti-stigma campaigns need to be continued and reinforced in emergencies, or the impact of stigma could worsen.* While the research finds no evidence of increased stigma in emergencies, existing stigma has a worse impact, especially in slow-onset natural disasters, when those with HIV lose social capital and community support. In rapid-onset natural disasters, stigma deters people from revealing their status and accessing the humanitarian relief services they need.

*Dialogue and collaboration between actors in the humanitarian and HIV response is critical.* Case studies, particularly in Sri Lanka, show how HIV prevention and treatment came on the back of the emergency response, highlighting the importance of increased collaboration between actors in the humanitarian and HIV sectors. Policy-makers and programmers in these sectors need to work together to develop joined-up thinking and programmes that consider both immediate and long-term needs.

*It is vital to target people living with HIV for specific and long-term support, especially in slow-onset natural disasters.* The duration of an emergency is crucial in assessing how people living with HIV cope. Evidence from northern Kenya shows they are more affected than others the longer the emergency goes on. While others start to rebuild their livelihoods, those living with HIV tend to remain in a 'micro-emergency'. Neglecting them will undo progress on the HIV epidemic and undermine efforts to achieve Universal Access and, more broadly, poverty reduction.

There are similarities and differences in the impacts of emergencies on vulnerability, ability to cope and service provision. Whether these translate into new HIV infections depends on existing HIV prevalence, numbers of sexual partners, mobility and the types of interactions between people. It reinforces the need for a contextual analysis of every humanitarian crisis situation in relation to the implications for HIV, rather than the application of a standard set of interventions. Although normative guidance is required to help mainstream HIV into humanitarian responses and set minimum standards (e.g. IASC, 2005), our research shows that one size does not fit all, nor do the same priorities and needs occur in the same way in all emergencies.

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