

## **HIV and Emergencies: Central African Republic Country Case study**

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\* Disclaimer: The views presented in this paper are those of the authors and do not necessarily represent the views of the World Food Programme and UNAIDS

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## List of Acronyms

APRD	Armée Populaire pour la Restauration de la République et la Démocratie/ Popular Army for the Restoration of Democracy
ART	Anti-retroviral Therapy
BCC	Behaviour Change Communication
CAR	Central African Republic
CEMAC	Communauté Economique et Monétaire de l’Afrique de l’Ouest
CNLS	Comité National de Lutte Contre le SIDA/National Committee to Fight AIDS
CSWs	Commercial Sex Workers
DDR	Disarmament, demobilisation and reintegration
DRC	Democratic Republic of Congo
ECCAS	Community of Central African States
FACA	Forces Armées Centrafricaines/Central African Armed Forces
FDPC	Front Démocratique pour le peuple centrafricain
FGD	Focus Group Discussion
FOMUC	Force Multinationale en Centrafrique
FOSA	Formations Sanitaires/Health centres
GP	Garde Présidentielle/Presidential Guard
HBC	Home Based Care
HDPT	Humanitarian and Development Partnership Team
ICC	International Criminal Court
ICG	International Crisis Group
ICRC	International Committee of the Red Cross
IDI	In-depth Interview
IDPs	Internally Displaced People
IDUs	Injecting Drug Users
INGOs	International Non-Governmental Organisations
IOM	International Organisation for Migration
KAP	Knowledge, Attitudes, Practices
KIs	Key Informants
MERLIN	Medical Emergency Relief International
MICS	Multi-indicator Cluster Survey
MDM	Médecins du Monde
MSF	Médecins Sans Frontières
MSM	Men who have Sex with Men
NFIs	Non-food items
OCHA	UN Office for the Coordination of Humanitarian Affairs
OIs	Opportunistic Infections
PEP	Post-exposure Prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Paper
PSI	Project Services International
RECAPEV	Réseau Centrafricain de Personnes Vivant avec le VIH/SIDA
SGBV	Sexual and gender-based violence
STIs	Sexually Transmitted Infections
UNDAF	United Nations Development Assistance Framework
UFDR	Union des Forces Démocratique pour le Rassemblement/Union of Democratic Forces for Unification
VCT	Voluntary Counselling and testing
WFP	World Food Programme

## Executive summary

### Background and context

The Central African Republic faces a critical challenge to address the threat of HIV as it enters into a new post-conflict phase. Already facing the highest prevalence rate in Central Africa, the political turmoil and insecurity experienced over the last decade have slowed the introduction of vital HIV prevention, care and treatment programmes. At the same time, large sections of the population have become more vulnerable to HIV transmission as a result of displacement, the destruction of basic services and general impoverishment. This creates a situation where HIV is likely to flourish unless it is made into an absolute priority in all forthcoming interventions, particularly in the north of the country which has suffered the brunt of the conflict. To prevent such a scenario, speedy and effective HIV interventions need to be integrated more thoroughly into the humanitarian efforts that are currently underway and not left until after other more visible needs have been tackled.

The high national prevalence rate of 6.2% reflects a serious and generalised epidemic that affects most groups within society. Young women are particularly affected, while prevalence tends to be higher in urban areas and among the better off socio-economic groups (notably teachers, uniformed personnel, migrants, commercial sex workers (CSWs) and transport workers). Exclusion from the political process and the failure to achieve meaningful development have fed the successive political crises that gave rise to armed resistance. Fear of attack from the various armed movements has led to mass displacement and the collapse of the rural economy, resulting in a crisis of protection for more than 1 million people.

Despite the recent peace accords between the government and rebel groups, the current situation remains unstable. The local population has been facing multiple security threats: various rebel groups who have committed serious abuses against sections of the population under their control, particularly rape; the Central African Armed Forces (FACA), who have been responsible for widespread destruction of villages and massacres in areas suspected of sympathising with the rebels; incursions by groups implicated in wider regional conflicts, namely Darfur, Chad and, most recently, the Lord's Resistance Army from Uganda; and organised bandits known as *zaraguina* or *coupeurs de route*, who regularly kidnap hostages for large ransoms and cause widespread destruction (currently the most serious threat).

As a result, nearly 300,000 people are estimated to have fled their homes in 2007, two thirds of whom are inside the country, particularly in the North West, and another third who have taken refuge in Chad and Cameroon. 5000 refugees from Sudan have also fled to CAR, where they are mainly concentrated in an isolated part of the country's north east.

Widespread insecurity has crippled CAR's fragile economy and decimated rural production, on which the majority of the country's population depends. Violence has disrupted marketing networks and destroyed basic infrastructure. Agricultural productivity, always low, has declined still further as the areas under cultivation have shrunk as families have left their land or have chosen to plant less because they are unable to sell their produce due to lack of markets. Oxen for ploughing have died or been sold, while hunter-gathering activities have been curtailed. Livestock herders, a particular target for the *zaraguina*, have fled the country or been forced to sell off their herds in order to pay crippling ransoms. Production of cotton and coffee, previously important cash crops, has collapsed due to declining terms of trade and pillaging. As a result, food prices have risen, affecting urban as well as rural areas, thereby increasing the pressure on vulnerable groups, including PLHIV.

Because of this prolonged instability, the country's health indicators have deteriorated sharply over recent years. Infant and maternal mortality have increased sharply, reflecting problems in the delivery of quality health services and difficulty of access due to distance, cost and insecurity. Services are particularly inadequate in isolated rural areas, with most health professionals

concentrated in the capital, Bangui. In the face of increasing poverty, application of a strict cost recovery policy also restricts the ability of significant sectors of the population to access adequate health care.

Acceleration of the fight against HIV/AIDS is a key component of government and donor policies and recent progress is to be applauded. However, the infrastructure necessary for proper care and treatment is still not fully in place outside the capital and is so far reaching only relatively small numbers of people. There are still too few centres where ARVs, VCT and PMTCT are available, particularly in rural areas and in the north of the country. Plans exist to extend the coverage, but given the scale of the need and the large distances, insecurity and transport problems faced by many people, access is likely to remain problematic for large segments of the population. IEC/BCC efforts have helped raise awareness, although activities remain primarily concentrated in Bangui. Condom use, on the other hand, is very low, with demand far outstripping supply.

Cultural factors that have contributed to the spread of HIV/AIDS include widespread gender discrimination, whereby women have an inferior status and are economically dependent on men. Rural girls are particularly ill-favoured in terms of their right to education, while early marriage and child-birth is commonplace. At the same time, marital bonds are often loose and sequential relationships are the general norm. Stigma against PLHIV is also strong, sometimes leading to rejection by the family.

### **The programmatic response to the emergency: general and HIV related**

With the 2005 democratic elections, a period of donor re-engagement with CAR has been inaugurated that has culminated in the adoption of a Poverty Reduction Strategy Paper and the allocation of significant amounts of international aid. African and European peace-keeping troops have been sent to the country to help provide greater security in parallel with the on-going national reconciliation process. In parallel, international humanitarian organisations have returned to the country to mount a significant emergency response. In its early stages this has helped reintroduce basic medical services to the local population, distribute food aid and seeds, as well as rehabilitate water supply systems and schools. A Consolidated Appeal aimed at assisting 1 million people has been launched for 2008

Despite some notable exceptions, the fight against HIV/AIDS has not generally been prioritised in the course of the emergency response to date. The activities that are planned are not accompanied by a clear strategy and are instead dependent on individual NGOs to implement at a project level. Consequently, there is unlikely to be any regular monitoring of the extent to which such interventions are being implemented. Moreover, condom distribution, a crucial preventive measure, has been given relatively little attention in the appeal and none of the 4 main HIV projects within the appeal had received any funding as of 15 May 2008.

### **Vulnerabilities to contracting HIV during the emergencies**

The various episodes of violence that have characterised CAR's recent history have been marked by repeated incidents of rape and SGBV. Inevitably, this is a factor that favours the transmission of HIV. A number of NGOs have initiated activities to address this problem but PEP kits for treatment of rape victims are not always widely available.

Vulnerability to HIV has also increased as a result of the growth of commercial sex work. The deteriorating economic situation pushes more young women into making their living in this way, particularly IDPs. Increased competition therefore encourages CSWs into accepting unprotected sex. In this context, the presence of national and international troops has tended to act as a stimulus, even attracting some sex workers from Bangui to towns where the troops are based.

Similarly, uniformed personnel, whether members of the armed forces or rebel soldiers, can be considered at increased risk of HIV as a result of the conflict. Rates of HIV appear to be high

among the FACA and a group of ex-rebel combatants met by the research team in Bouar. The former are issued with condoms, but the number is insufficient and the supply irregular. The latter do not have access to free condoms, VCT or health care even though some display symptoms of STIs. Unlike army personnel, however, they do not have access to food or any form of reliable income, a situation which - in the case of the women particularly - is liable to push them into transactional sex.

Despite the fact that IDPs generally manage to stay together as a family unit, a number of women interviewed had either lost their husbands or taken refuge without them. Widows/abandoned women constitute a particularly vulnerable sub-group. Elderly and handicapped people are sometimes left behind in the original villages and can be presumed to be living in an extremely precarious state. IDPs reported various changes in their lifestyles, including reliance on paid daily labour as their main source of income, dependency on food aid, an inability to pay for medicines, poor hygiene, and the fact that they can no longer send their children to school. Such conditions are likely to reduce their immunity to illness, thereby increasing their vulnerability to HIV, or push them into behaviour that puts them at greater risk of contracting the virus. Any IDPs that are already HIV positive are likely to find themselves less resistant to the disease, making them fall sick more quickly.

### **Resilience and coping during emergency situations**

In response to the various security threats, large numbers of people have sought refuge in the bush, in neighbouring towns or by crossing the border. Sometimes they move back and forth between different locations depending on the security situation in a given area. There is only one IDP camp inside CAR, in the town of Kabo, where about 5000 people are living. Those in towns are in a slightly less precarious position since they can find daily labour and access humanitarian assistance, although health care is often still beyond their reach.

### **Vulnerabilities of PLHIV during the emergency**

PLHIV households tend to live in greater poverty than other households because they have to cope with more dependents, increased health costs and reduced incomes. In response, they sell off productive assets and their inability to access health care and schooling declines. Access to ARVs has only recently become a reality for many PLHIV in CAR. These life-saving drugs are still far from widely available, particularly for those in more remote rural areas. There have been severe difficulties in introducing planned facilities in areas affected by conflict due to the lack of trained personnel willing to work in these regions. Even in some areas where ARVs are available, supply problems can occur. Some people are reported to have abandoned treatment because of high transport costs or because they were unable to reach the facilities due to conflict and insecurity. However, there is no evidence of increased stigma or discrimination because of the emergency.

### **Resilience and coping amongst PLHIV affected by the conflict**

PLHIV in the capital have responded to their increasingly difficult situation by reducing the amount of food they eat, by getting into debt or begging. Those eligible for food aid sometimes resort to selling these supplies in order to afford ARVs and other basic supplies. A loose network of associations of PLHIV has been formed and has been given official recognition. The federation has helped its members gain access to various economic activities.

### **The effects of the emergency on service provision – health services**

While access to preventive services and treatment is slowly improving in CAR, insecurity has directly affected medical staffs, who are deterred from working in conflict-affected parts of the country, except where significant bonus payments are made by NGOs. The lack of qualified personnel is a severe constraint in implementing treatment programmes for PLHIV. The conflict has also led to the widespread destruction of health centres: one third are out of action after being looted or falling into neglect. Moreover, falling incomes have reduced people's ability to access

basic health care because it has become prohibitively expensive, although humanitarian NGOs operating in the conflict areas offer services for free.

As a result of the insecurity, roll-out of nationwide VCT, PMTCT and ARVs has been delayed, with the northern regions worst affected by the slow pace of implementation. The humanitarian crisis has slowed down training and supervision, as well as IEC/BCC activities. Security issues also gives rise logistical problems, such as ensuring adequate supplies of drugs and materials. In some cases, new buildings have been constructed and staff recruited, but the VCT centres are not yet functional. Key informants consulted appeared not to be aware of the time-table for their opening. PMTCT services are available in some conflict-affected areas but not others.

There is a severe shortage of condoms in many parts of the north. While many of the participants in the focus groups understood the importance of using condoms, they do not readily have access to them. This situation seems to be partly due to problems in the supply chain, but is made worse by the prevailing insecurity.

Secure blood supplies remain a challenge in most of CAR. In most provincial hospitals, blood is supplied by family members and is screened before being used but the amount made available in this way is very small. Moreover, essential hospital supplies such as surgical gloves are not always available.

### **The effects of the emergency on service provision – other basic services**

The prevailing violence and insecurity has destroyed the already limited social and productive infrastructure, forcing many people into growing poverty and a return to a subsistence economy. Real per capita income has fallen to become the lowest in the Central African region, while the incidence of poverty has increased. Food security is also becoming a serious problem.

Water and sanitation services have been among the casualties of the conflict in CAR. Water supply and village pumps have been destroyed or fallen into disrepair. Education has also been severely affected. The gross school enrolment rate has fallen as a result of high costs, insecurity and distance, a situation which tends to penalise girls in particular, since they have significantly lower enrolment rates than boys. The conflict has also led to schools being destroyed and teachers fleeing the affected areas.

### **Key findings**

- The roll-out of VCT centres, PMTCT facilities and distribution of ARVs has been slow, at least in part due to the difficulty in posting staff to remote rural areas suffering from conflict and insecurity. Where HIV services do exist, it is partly thanks to NGOs who make additional salary payments, but the state does not have funds to make similar incentive payments. The existing level of provision is not sufficient to enable much of the rural population to have access to HIV prevention and care services.
- The cumulative effect of the multiple crises in CAR has been to stifle production and internal trade, crippling the rural economy and rendering large sections of the population significantly more vulnerable (among them IDPs, PLHIV, CSWs and some ex-combatants). Reduced internal commerce, on the other hand, is likely to have reduced the exposure of transport workers, a group previously considered to be at high risk of HIV.
- The conflict and insecurity has had a serious impact on the capacity of these vulnerable groups to contribute towards the costs of health care. Consequently, the cost-recovery policy currently applied, which includes drugs for STIs and IOs, often prevents them from gaining access to appropriate care and treatment.

- HIV interventions have tended to be side-lined in favour of immediate life-saving measures pending an improvement in the security situation. While protection measures are essential, HIV needs to be tackled in parallel with humanitarian efforts and not left until a later stage. The conditions for an explosion of the epidemic exist (health system close to collapse, displacement, basic prevention and treatment measures not in place). While other more visible priorities are absorbing much of the efforts of the humanitarian community, HIV is almost certainly spreading rapidly.
- Demand for condoms far outstrips their availability. Groups such as IDPs and other poor sections of the population cannot afford to use their scarce cash to purchase condoms.
- No specific provision appears to have been made for targeting HIV positive IDPs, including those who do not know their status. Those in the Kabo refugee camp or attending distributions of humanitarian aid are an easy target group who could be the focus for IEC/BCC as well as VCT. The particular needs of this sub-group – in particular the fact that they may shortly be returning home to areas where access to ARVs will be more difficult – should be taken into account and planned for.
- Despite the existence of widespread and repeated incidents of rape, PEP kits are not readily available in most parts of the country.
- There are indications that some ex-combatants who have been demobilised but have not been integrated into a formal reinsertion programme are seriously affected by HIV. They should be considered a particularly vulnerable group for whom a programme should be developed.
- There are credible reports to indicate that the presence of international peace-keeping troops is leading to an increase in commercial sex work. Such practices compromise efforts to control HIV both in CAR and the sending nation. It is imperative that the issue is taken seriously by military authorities and the international bodies overseeing their missions.
- There is a dearth of qualitative information about HIV-related services and PLHIV in CAR. A better understanding of how different groups are likely to be affected by the disease is necessary in order to tailor responses appropriately, particularly IDPs.

### **Recommendations**

- Targeted distribution of free condoms is a crucial and cost-effective step towards halting the spread of HIV and must be considered an urgent priority. Various means of distribution can be considered, such as including them as a routine item in all hygiene kits or during food distributions. Information about correct condom use should also be provided. Military personnel should be given access to condoms at all times.
- Opening of the remaining VCT centre in Birao should be seen as a key priority, while more detailed plans and targets need to be developed for extending the roll-out of ARV, VCT and PMTCT services to the sub-prefecture level. Adequate resources will need to be allocated by donors to enable this to happen at the earliest possible date.
- A review of the cost-recovery policy should take place that acknowledges the high level of vulnerability of groups such as IDPs and PLHIV. Greater use should be made of exemptions

from payments for treatment and funds made available by donors in order for this to be possible. PLHIV should not have to pay for treatment for OIs.

- Given the already high rates of HIV in CAR and the factors identified in this report that are likely to fuel the epidemic still further, HIV cannot be seen as an 'add-on' to other humanitarian interventions and a response should be mainstreamed into all projects. All appeals should explain what the impact of the planned work is likely to be on HIV, what action is envisaged that will help reduce HIV transmission. HIV-linked indicators and budgets should be specified. If necessary, extra resources should be made available in order to carry through this undertaking. Adequate monitoring must take place to assess progress against these indicators and levels of funding obtained.
- International donors should take rapid steps to ensure full funding for the key HIV projects in the Consolidated Appeal for CAR for 2008.
- Strategies need to be developed to target IDPs' needs with respect to HIV prevention, care and treatment. These strategies should allow for the fact that IDPs are mobile and may return to their places of origin. To facilitate this step, more health professionals need to be trained in prescribing ARVs.
- Strategies to make more PEP kits available on a timely basis at a decentralised level need to be developed. More medical staff should also receive the necessary training to deal with suspected cases of SGBV discretely.
- The ex-combatants in Bouar and elsewhere should be quickly integrated into a demobilisation programme that will provide them with a livelihood. They should be given emergency aid (e.g. hygiene kits, including condoms), treatment for STIs, and enabled to have access to the local VCT programme.
- All international troops stationed in CAR should be given mandatory HIV training and encouraged to come forward for VCT. Condoms should be made readily available to them. Peace-keeping budgets should ensure that adequate resources are put aside to this effect.
- More studies need to be commissioned in order to obtain a better understanding of the social dimensions of the HIV epidemic in CAR.

## 1. Introduction

ODI, in partnership with WFP and supported by UNAIDS, is carrying out a study on HIV and emergencies. The study aims to assess the impact, which different types of emergency situations have on people living with HIV (PLHIV), HIV-related services and vulnerabilities to new HIV infections. It is in 2 phases: the first phase involves a literature review with 3 inter-related aims: 1) to review existing literature on HIV and emergencies; 2) to develop a conceptual and operational framework for thinking about HIV in emergencies situations; and 3) to identify gaps in the literature and areas for further exploration. Phase 1 has now been completed (see Samuels and Proudlock, 2007). Phase 2 aims to go somewhat towards filling in the gaps through carrying out a number of case studies. In order to obtain as wide-ranging a perspective as possible, the countries selected for the case studies represented countries facing different kinds of emergencies, different prevalence rates and more generally different kinds of contexts and cultural settings. Selected countries include: Haiti, Sri-Lanka, Mozambique, Central African Republic (CAR) and Kenya.

The current report focuses on the CAR country case study. CAR was selected for being a complex but largely forgotten emergency in a high prevalence country. At the time of writing, it is going through a delicate post-conflict period marked by serious insecurity. Nevertheless, given the protracted and over-lapping nature of the humanitarian situation in CAR, and because it is inter-linked with the failure of development policies, it is hard to draw a distinct line between the situation before and after the emergency

After providing an explanation of the methodology used for the study, this report gives an overview of the country context, paying particular attention to the development of the HIV epidemic and of the emergency situation. It subsequently takes a brief look at the emergency response and the extent to which this has incorporated HIV before attempting to identify some of the key impacts the humanitarian situation has had on HIV. It concludes with some findings and accompanying recommendations for tackling HIV related vulnerabilities and subsequent coping in the Central African context more effectively.

## 2. Methodology of assessment

This report is based on a 10-day mission to the Central African Republic by a team composed of one international and one local consultant, who were joined for the field visit to Bouar by the local UNHCR HIV focal point. Four days were spent on a field visit to the town of Bouar in Nana Mambere prefecture, while the remainder of the time was spent in the capital, Bangui. The mission, originally planned for 13 days, had to be curtailed due to the unfortunate personal circumstances of the international consultant which prevented a second field visit to Bossangoua (Ouham Prefecture) from taking place.

The location for the field visit was selected in accordance with the following criteria:

- areas directly affected by the humanitarian emergency
- areas that were accessible given the time-frame available and in the light of security considerations
- areas not visited by the recent Inter-agency mission, (see below),
- relatively high HIV prevalence rates
- relatively high incidence of poverty

The research team sought to build synergies between its work and that of the Inter-agency mission, led by UNHCR, which conducted a rapid assessment on HIV in conflict-affected areas in

CAR in the period immediately preceding the field work for this report<sup>1</sup>. This mission aimed to gain a better understanding of the vulnerabilities and risk of exposure to HIV of IDPs and of the host population, as well as to assess the response of the different actors involved in the fight against the HIV epidemic. The sites for the field visits to be made in the course of the current study were chosen in order to complement the ones visited by the Inter-agency mission, and one of the team leaders from the first study was able to join the research team brought together for the purposes of this research. Where possible, the preliminary conclusions from the Inter-agency mission have been used to triangulate the findings of this study and cross-references have been made on a number of occasions.

The current study suffered from a number of limitations. The primary constraint encountered was in relation to the security issue, which meant that certain areas were inaccessible to the research team, particularly given the short amount of time available for the work. Given these circumstances, it was not possible to visit the northern area of Vakaga that borders Sudan and Chad and which is experiencing the knock-on effects of the conflict in Darfur. Time restrictions also meant that certain key figures could not be met. It is also important to point out that, also due to security restrictions, the various groups interviewed, including the IDPs, were urban-based and are therefore not representative of the entire population that has been affected by the humanitarian crisis. Many IDPs remain confined to isolated bush areas where they can be assumed to be living in even harsher conditions than those of the people met during the course of the field work for this study.

Unfortunately, it was not possible to meet representatives of the international military forces based in CAR in order to obtain information about the extent that training on HIV/prevention measures have been taken into account. This was primarily because their field operations are decentralised and could not therefore be reached given the limited time-frame of the mission. Their presence was, nonetheless, very visible (patrols, presence in local bars, etc) in some instances, and the research team discussed their behaviour with the local population.

A further constraint was the lack of detailed studies on HIV and various aspects of rural livelihoods. It appears, for instance, that no proper KAP studies have been carried out in CAR, although UNICEF is planning to carry one out with youth in May 2008<sup>2</sup>. Nor is there much analysis of the social factors driving (or restricting the spread of) the illness, in particular the cultural values of different groups within the population; similarly, there is no reliable information about HIV in prisons, MSM or IDUs in CAR. Even data about rates of STIs is unavailable since the figures currently produced by health centres are not disaggregated.

A total of 10 IDIs were conducted with key informants in Bangui. Unfortunately, these did not include the Health Minister or a representative of the National Committee to Fight AIDS (CNLS) due to the former's travel and work commitments during the period of the mission in Bangui and the fact that the timing coincided with the General Assembly of the National Committee to Fight AIDS. In Bouar, 8 IDIs were carried out with local health professionals, development and NGO workers and local military officials (see Annex A) as well as 5 focus groups with PLHIV, IDPs, CSWs and ex-combatants (see Annex B).

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<sup>1</sup> Evaluation Rapide de la situation des PDI et le VIH en RCA (draft report), April 2008. The mission, which was facilitated by UNHCR and UNAIDS, was conducted by a joint UN HIV team (UNFPA, OCHA, WHO, WFP, UNDP, UNICEF) together with state representatives (CNLS and MSPPLS) as well as local civil society (RECAPEV) and NGOs. It took place from 28 Feb – 4 March 2008.) during which time teams were sent to Bozoum and Paoua/Bémal (Ouham Pende prefecture), Kaga-Bandoro/Quandago (Nana-Gribizi) and Kabo (Ouham).

<sup>2</sup> IDI with HIV/AIDS Programme Officer, UNICEF.

### 3. Country context

#### 3.1 HIV epidemiology

The latest and most reliable figures of HIV prevalence in CAR are from the Third Multi-indicator Cluster Survey (MICS) that was carried out in 2006 and which put the prevalence rate at 6.2%<sup>3</sup>. This confirms a serious and generalised epidemic that is affecting CAR more than any other country in the Central African region, and places the country as the ninth most seriously affected in the world (OCHA, 2008 p.2). HIV has thus become one of the major sources of mortality and morbidity among adults in CAR; as illustrated by the fact that 50% of all hospital beds are now occupied by AIDS cases (UNDP, 2006)

The national prevalence rate of 6.2% hides significant regional disparities, with rates ranging from 14.2% in Haut Mbomou in the east of the country to 3.2% in Ouham in the North West<sup>4</sup>. Prevalence is also twice as high among women as men (8% and 4% respectively), and is considerably higher in urban than in rural areas (8.3% as compared with 4.7%). All age groups of both sexes are affected, but of particular significance is the fact that the rate among young women is nearly 6 times higher than for young men of the same age (5.7% as opposed to 1%), reflecting the fact that women are infected at a younger age than men. In addition, women of higher socio-economic groups tend to be relatively more severely affected than those from less well-off backgrounds.

Among the direct consequences of the spread of the illness have been loss of life, (24,000 deaths have been attributed to the disease, CNLS, 2006), a loss of human resources and productivity, and increasing economic and social costs. At a micro level, the illness results in a loss of income for affected families (idem) and a process of impoverishment. 250,000 people were estimated by UNAIDS to be living with HIV in CAR in 2006, of which 24,000 are children under 18; 140,000 children are believed to have been orphaned by HIV in the country (UNDP, 2007), with the number projected to reach 211,000 in 2015 (Rep. Centrafricaine, 2007). 30.5% of children are considered orphans and vulnerable children, although there is a higher proportion in urban than rural areas (35% as opposed to 22%, MICS, 2006).

The main mode of transmission is heterosexual. Among the most severely affected economic groups are teachers, men in uniform, migrants, commercial sex workers (CSWs) and transport workers. Among the most vulnerable groups to HIV infection are women and youth, with more than 50% of new HIV cases occurring in the 15-24 age group (MICS, 2006).

There are indications that knowledge of HIV is relatively widespread in CAR, although not yet adequate. A 2003 survey, for instance, found that 83.2% of women and 87.6% of men aged 15-24 were aware that systematic condom use can protect against HIV (UNDP, 2006), though it is important to note that awareness is slightly lower in rural areas and among women.

#### 3.2 History of emergency

Over the past 12 years, CAR has been affected by successive and overlapping bouts of armed conflict that have contributed to the current humanitarian crisis. The armed violence has come on top of policies that have failed to achieve meaningful development for the population, thereby creating a downward cycle of impoverishment and insecurity. Fear of attacks from the various armed actors -whether rebel groups, FACA, *zaraguina* or others (see below for further details) -

<sup>3</sup> These statistics are significantly lower than previously published figures, a fact which key informants say is likely to be related to the method of calculation rather than any drop in prevalence rates. This ambiguity, however, makes any monitoring of trends problematic.

<sup>4</sup> It is important to note that the prefecture of Vakaga, which borders Chad and Sudan, was not included in the survey because of difficulties in collecting data due to the insecurity. However, the situation there is unlikely to be very different from neighbouring prefectures: Bamingui-Bangoran (7.7%) and Haute-Kotto (10.6 %).

has led to widespread displacement and the collapse of agricultural production. The incapacity of state authorities to guarantee security for the population in rural areas has led some commentators to characterise today's situation as a crisis of protection.

As a result, the Central African population, particularly that in the north, have faced multiple security threats over the last decade. Their combined effect has been to cause widespread displacement and destroy economic activity. Among these threats, the most significant have been the following:

- Various rebel groups, who have taken up arms in response to serious disparities in regional development and exclusion from the political process: the APRD (based largely in Ouham, Ouham Pende and Nana Gabrizi prefectures in the North West), UFDR (active in Bamingui-Bangoran and Vakaga prefectures) and FDPC. Their forces have engaged in violent confrontations with the army. While in some cases offering protection to the local population, the rebels have been accused of serious abuses, including killings, widespread rape, brutality, looting, forced taxation and the recruitment of child soldiers (HRW, 2007).
- The FACA themselves, together with the even more brutal Presidential Guard, have been accused of widespread extrajudicial executions and destruction of hundreds of villages in reprisal against those suspected of sympathising with the rebels. During the course of 2007, President Bozizé admitted that state forces have been responsible for serious abuses and declared his intention to bring such violations under control. Although no penal sanctions have been applied and impunity remains, such violent excesses are reported to be occurring less frequently<sup>5</sup>, although isolated incidents remain.
- Various transgressions of the border by other armed groups in the region. There are regular incursions from Chadian troops and rebels who come across the porous border to pillage. In addition, the spill-over from the Darfur conflict has already led to the arrival of several thousand Sudanese refugees and could potentially become more serious.
- Zaraguinas (otherwise known as coupeurs de route or highwaymen), i.e. organised bandits from various parts of Africa who allegedly benefit from the complicity of local people. While familiar in other parts of the region, the zaraguina have taken on considerable strength in CAR as a result of the inability of the army to control the territory and the prevailing climate of impunity. They operate throughout much of the country and, with the reduction in hostilities between FACA and the rebel groups, are now considered to be the most serious threat to civilians in the north of the country. They are responsible for repeated incidents of highway robbery, kidnapping<sup>6</sup>, burning and pillaging of villages, as well as killings. In general, the coupeurs de route are unable to function in rebel-held areas although some reports point to a blurring between the two groups, with some rebels accused of being 'rebels by day and bandits by night'. Zaraguina activity has caused massive displacement by those afraid of or targeted by them, causing them to abandon their traditional livelihoods<sup>7</sup>; reduced local and international trade; and prevented the return of refugees. In response to their presence, a number of poorly armed self-defence groups have been formed in certain villages.

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<sup>5</sup> See for instance the interview with Toby Lanzer, UN Humanitarian Coordinator in CAR, IRIN Humanitarian News and Analysis, 3/4/08.

<sup>6</sup> Many of the victims are children. Families are forced to pay significant sums for their release (3 million CFA or \$6,600 in one news report) which can only be raised by selling assets and livestock in particular.

<sup>7</sup> This situation has forced many people, particularly the Peuhl or M'bororo ethnic group, to abandon their traditional lifestyle and flee to towns or over the border into Cameroon or Chad. Others are said to have turned to banditry themselves.

- In the period preceding and immediately following the coup d'Etat of 2003, the capital, Bangui, and other areas of the country were subject to serious violence, including massacres of civilians and rape (see section 5.1.1.1 below). In the north of the country, civilians also became the target of indiscriminate killings, accompanied by attacks on the economic and social infrastructure (ICG, 2007). In 2007, the International Criminal Court announced its intention to investigate abuses committed during the fighting from 2002-03, a process which has recently led to the issuing of an arrest warrant and subsequent arrest of Jean-Pierre Bemba, the leader of the Congolese fighters.

The United Nations estimates that 1 million people were affected by the resulting humanitarian situation in 2007 and that nearly 300,000 had fled their homes. According to UNHCR, there are about 197,000 internally displaced persons (IDPs) inside CAR (a figure equivalent to 13.6% of the population in the north of the country, OCHA, 2008 p.2) plus approximately 101,000 refugees outside the country's borders, mainly in Chad and Cameroon. There are also 4900 refugees from Sudan, 3000 of whom arrived over the border to Sam Ouandja in the first half of 2007<sup>8</sup>. According to estimates by OCHA/UNFPA, approximately two thirds of IDPs in CAR are concentrated in the prefectures of Ouham and Ouham Pende in the north west of the country.

Significant progress has been made over the past year towards ending fighting in the north of the country and to overcoming the underlying conflicts which have given rise to the rebel movements. In April 2007, a peace agreement was signed between the government and the UFDR forces in the north east, while after a period with an informal truce, another has recently been concluded with the APRD in the North West. In parallel, considerable progress has been made towards holding an inclusive political dialogue that is intended to help end the cycle of instability and violent conflict that has so crippled the country. A 25-member preparatory committee has concluded its work, in the expectation that the full dialogue process will be launched by June 2008.

Nonetheless, occasional clashes continue between the army and the APRD in the North West and UFDR forces have yet to be reintegrated into national life, demonstrating how fragile the national reconciliation process is. According to the UN's Humanitarian and Development Partnership Team (HDPT), 'considerable concessions will have to be made if this dialogue is to be successful'<sup>9</sup>. At the same time, credible reports of violent incursions into CAR by Ugandan rebels in late February/early March 2008 serve as a reminder of how regional factors can continue to destabilise the country.

### 3.3 Livelihood contexts

Although the Central African Republic has considerable natural and mineral wealth (gold, diamonds, rich forests, good and abundant agricultural land, etc), these resources have remained largely unexploited and have never been used for the benefit of the population. The size of the country and the poor state of its infrastructure mean that many regions remain extremely isolated, particularly in the rainy season when they become practically inaccessible<sup>10</sup>. Nonetheless, river and road transportation are essential for trade and communications and cross-border population movements take place regularly, with consequent risks for HIV/AIDS transmission.

The country's population is predominantly rural (62%) and young (50% are aged under 18). Agricultural production is the mainstay of the economy and employs 75% of rural inhabitants (UNDP, 2006). However, this sector has been seriously disrupted over recent years as a result of

<sup>8</sup> UNHCR Fact Sheet – Central African Republic, April 2008.

<sup>9</sup> Final countdown for the inclusive political dialogue, HDPT CAR press release, 2 May 2008, accessed on 19 May 2008 at [www.reliefweb.int/rw/rwb.nst/db900sid/EGUA-7E9PL5?OpenDocument](http://www.reliefweb.int/rw/rwb.nst/db900sid/EGUA-7E9PL5?OpenDocument)

<sup>10</sup> It can take 2 weeks to reach Sam Ouandja, where the Sudanese refugees are concentrated, from Bangui during this part of the year CAR: Cornered in the Centre, Humanitarian and Development Partnership Team CAR, powerpoint presentation, January 2008.

insecurity, which has disrupted marketing networks and destroyed basic infrastructure. Food crops account for the largest part of agricultural production (particularly manioc and, to a lesser extent, corn and peanuts), although livestock, fishing and hunter/gathering activities are other important components of rural livelihoods. Production of cotton and coffee, previously important cash crops on which 15% of the rural population depended, has collapsed as a result of declining terms of trade and the destruction of productive infrastructure due to internal conflicts<sup>11</sup>.

Productivity in the sector is low, with farmers having difficulty accessing necessary inputs (e.g. fertiliser, tools, credit and technical support) as well as marketing their produce due to the poor road network and insecurity. Consequently, they have no incentive to cultivate more than small areas of land. Moreover, they use only rudimentary means of transport, which limits the amount of produce available on the market and pushes up prices<sup>12</sup> (UNDP, 2006). The various crises have meant that oxen for ploughing have died or been sold off, while hunter-gathering, which used to provide an important source of protein in people's diet (game, caterpillars), no longer takes place to the same extent. According to a WFP/UNICEF study (2007), increasing areas of land are being left uncultivated due to the lack of incentive for farmers to grow crops that they will not be able to sell. 10% fewer households were able to plant their fields in 2006 when compared with 2003-04, while the area cultivated has been halved (falling from 0.6 ha per person to 0.3 ha). Ouham, Ouham Pende and Nana Gabrizi, areas that used to be considered the country's breadbasket, are among the prefectures most severely affected due to frequent rebel and *zaraguina* activity. Livestock production has also been severely affected by the humanitarian situation. Sixty percent of cattle herders are estimated to have left the country after having been the target of *coupeurs de route* (OCHA, 2008).

The 180,000 people who make their living through small-scale diamond production, concentrated in the east of the country, on the other hand, have been relatively unaffected by the direct effects of conflict and insecurity (UNDP, 2006).

With the decline of the country's small industrial base, the urban population is increasingly reliant on a growing informal sector (UNDP, 2006). Nonetheless, poverty is slightly less widespread in cities, where 68% live below the poverty line, as opposed to 73% of rural households. Urban dwellers also benefit from better access to basic services and have been relatively unaffected by the conflict and insecurity that has affected the country over the last few years. Nonetheless, food shortages have led to increased prices, presumably aggravating the food insecurity that affects vulnerable families such as those with PLHIV (see Section 5.2.1).

### 3.4 Health environment prior to the emergency

The public health system is organised around 7 regions which are sub-divided at the prefecture level into operational units. Health care is delivered at the community level through a system of dispensaries, health centres and hospitals, with referrals made to regional university hospitals and specialist centres at the central level.

Health indicators have tended to deteriorate sharply over recent years. Infant mortality, for instance, has increased from 97 per 1000 in 1995 to 132 per 1000 in 2003, largely as a result of malaria, the prevalence of which is 32% for children under 5 (UNDP, 2006), combined with other serious childhood conditions such as respiratory infections, diarrhoea and malnutrition. Thirty-eight percent of children under 6 have retarded growth, one in 10 children suffers from severe malnutrition, and 74% of those aged 6 -36 months lack vitamin A (OCHA, 2008). Maternal mortality also represents a serious and growing problem, doubling to 1355 deaths per 100,000 live

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<sup>11</sup> Three out of 4 cotton processing facilities were closed following the pillaging that accompanied the political struggles of 2002-03.

<sup>12</sup> Despite the relatively high prices at market, the producers receive only very low prices for their goods given the difficulty in accessing markets. As a result, they end up buying back the same produce during the hungry season that runs from April to June at high prices (UNDP, 2006).

births in 2003, as compared with 683 in 1988. This negative trend reflects increasing problems related to the quality of health services and, in particular, difficulty of access due to distance, cost and insecurity.

Among the major issues encountered are: a lack of funding, qualified personnel, facilities and equipment, as well as shortages of basic drugs. In addition, however, many facilities are hard to reach for rural dwellers. More than 25% of the population have to travel more than 25 kms to reach the nearest health facility, a distance which is impracticable in circumstances where transport is often not available. Moreover, there are serious regional disparities in terms of available facilities. There was only 1 doctor per 29,100 people in 2000 (OCHA/UNFPA), health staff are mainly concentrated in Bangui (including 90% of specialists), while there are currently only 900 nurses, 13 dentists and 17 pharmacists in the whole country (OCHA, 2008).

Health services have been severely under-funded over the last 10 years, representing less than 6% of the national budget. A cost recovery policy implemented in accordance with the 1987 Bamako Initiative is routinely applied in an attempt to help ensure more sustainable funding of drugs and services. However, this policy leads to prohibitively high costs being imposed on users, which in turn creates serious problems of access to health care given the extensive – and increasing – poverty of the majority of the population (see Section 5.3.1). In contrast, humanitarian NGOs operating in the conflict areas tend to offer services for free, although in some cases they are considering a transition towards a health insurance scheme<sup>13</sup>.

In order to address these serious failings, priority objectives for the health services identified in the recently adopted PRSP include improving the quality of care and ensuring availability of qualified health personnel; regular availability of drugs, including ARVs and laboratory materials; strengthening HIV prevention efforts in order to encourage behaviour change and reach vulnerably sectors of the population, including women and youth; improving care and treatment for PLHIV.

Acceleration of the fight against HIV/AIDS is a key component of governmental and donor policies in an effort to improve public health for CAR's population (it is one of 3 priority areas under UNDAF). The body responsible for HIV coordination is the National Committee for the Fight against HIV/AIDS (CNLS). Its work is guided by the National Strategic Framework for the Fight against HIV/AIDS 2006-2010 which identifies 3 main priorities:

1. Prevention (including prevention & treatment of STIs, wider availability and promotion of condom use, extension of PMTCT, improved blood supplies);
2. Improved treatment and care for PLHIV (specifically providing access to ARVs and drugs for OIs in all sub-prefectures of the country)
3. Promotion of a multi-sectoral approach, better management and coordination, and monitoring and evaluation.

Despite these commitments, there are tremendous difficulties in implementing a speedy and appropriate response in the current context, particularly as it affects the north of the country. A review of past national HIV programmes has revealed that decentralisation of measures to combat HIV has been very weak. A survey carried out on behalf of UNDP has shown, for instance, that 75% of health agents had been trained in HIV, compared with only 35% in rural areas (UNDP, 2006)<sup>14</sup>. Inadequate coordination and lack of involvement of different sectors in the fight against HIV has also been highlighted as a weakness of the system in the past (Central African Republic, 2007), although efforts are currently underway to improve this situation with the appointment of HIV focal points and the development of action plans in various ministries. Nonetheless, further efforts need to be made to ensure that adequate coordination takes place at a more decentralised level.

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<sup>13</sup> IDI with Medical Coordination, IRC.

<sup>14</sup> On the other hand, 90% consider their training to have been insufficient for them to be able to care for PLHIV.

Uncertainties around funding are cited as one of the factors that restricts effective planning to meet the scale of the challenge posed by HIV. Senior officials concur that the total funding available is insufficient given the scale of the epidemic in CAR (only \$7.7m in 2005, for example, UNDP, 2006). Today, funding is primarily received through the Global Fund, which has until recently been managed by UNDP. Funding through the 7<sup>th</sup> round will be transferred to the CNLS, with UNDP providing the necessary capacity building for this to take place. Further funding is received through other sources, e.g. the Congo/Obangui/Chari River Basin Initiative<sup>15</sup>, although this latter source does not cover ARVs. At present PEPFAR has no involvement in the country.

A number of institutions are involved with IEC/BCC, including local and international NGOs and UNICEF, which trains peer educators in various parts of the country. Activities aimed at young people and other target groups within the wider population are carried out in Bangui and other areas, but are largely inadequate outside the capital.

Significantly, condom use is extremely low in CAR. The procurement system is weak and unable to respond to the demand, particularly in rural areas. An estimated 12 million per year are required but the current supply, from all sources combined, including social marketing, is 6 million. In 2007, UNFPA was able to provide 1.5 million free male condoms, which were distributed primarily through state health facilities and NGOs, and they will be making 300,000 female condoms available in 2008. Subsidised condoms are also available in some areas through PSI at a cost of 50 CFA (12¢) for a pack of 3 but, according to several key informants, there are far too few sales points.

### **3.5 Cultural context prior to the emergency**

The Central African Republic is composed of more than 80 ethnic groups, the largest of which is the Baya (estimated to compose 33% of the population<sup>16</sup>), each with its own characteristics and traditions. Nonetheless, most people speak the national language, Sango. According to the latest census data, 50% of the population are Christian (25% Catholic, 25% Protestant), plus 15% Muslim and a further 35% who practice traditional religions. Traditionally women have an inferior status within society and are economically dependent on men. Since the adoption of the 2004 constitution, there is no longer any legal discrimination against women but it persists in practice. UNDP's gender-related development index ranks CAR as 148 out of 156, a situation which indicates severe gender discrimination. Some of the constraints on women's development identified in the National Policy for the Promotion of Equality and Equity are their lack of mobility, low self-esteem, lack of access to and control over resources (including education) a lack of access to information and technology and a lack of decision-making power at a household or higher level. Few women are present in posts of responsibility, while levels of domestic violence are high: 45% of women have been beaten by their husband or a relative (République Centrafricaine, 2005).

Despite the fact that the legal age for marriage is 18, early marriage - often polygamous - is common (58% of women are married before the age of 15, (CNLS, 2006) and tends to be accompanied by early child birth, which carries a number of health risks. Mainly for the same reason, the fertility rate is high (5.1 children per woman) while contraception use is low, only 19% of married women use any form of contraception (MICS 2006).

A number of traditional practices associated with female genital mutilation (FGM) are common. Excision<sup>17</sup> is practised on 36% of women, particularly in the Centre and North West, and is quite common among certain ethnic groups, often being carried out on girls as young as 9 or at the time

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<sup>15</sup> A regional HIV prevention programme aimed at reducing the threat of HIV transmission related to the intensive commercial traffic along these rivers adopted under the umbrella of ECCAS.

<sup>16</sup> The Banda, Mandijia and Sara constitute 27%, 13% and 10% respectively.

<sup>17</sup> A form of FGM described as 'partial or total removal of the clitoris and the labia minora (WHO Fact sheet #241 at <http://www.who.int/mediacentre/factsheets/fs241/en/> consulted on 10/6/08).

of marriage.<sup>18</sup> Muslim women are considered to be particularly at risk of HIV transmission due to strong cultural taboos and are therefore increasingly being targeted for prevention efforts.

Few young people are currently using condoms. MICS indicates that 25% of young women had sex with occasional partner over the last 12 months, of which only 41% used condoms, (MICS, 2006). Moreover, in many communities, marital bonds are loose and it is frequent for both partners to leave one relationship and enter another, in a pattern of sequential relationships.

PLHIV face a considerable level of stigma and discrimination. Market sellers find that people will no longer buy from them if their status is known, people do not want to sit next to them, and even family members make pejorative remarks because they believe that their relative will soon die<sup>19</sup> (although in focus groups some PLHIV report that with access to appropriate information, rejection by family members is reduced).

## 4. Programmatic response

### 4.1 What was the emergency response?

The 2005 democratic elections that confirmed François Bozizé as President, have helped introduce a period of transition and greater legitimacy for the government, leading to a normalisation of relations with donors and a resumption of international aid (suspended in 2002). In 2007 a Poverty Reduction Strategy Paper was finalised and was presented to a donor Round Table at which \$600 million of aid was pledged over the coming 3 years. It is built around 4 pillars, one of which is the development of human capital. Health and the fight against HIV, TB and malaria is one of the priority actions envisaged as part of this policy.

- In an attempt to help provide the security the country so badly needs, various international forces are now present in the country. They are:
- FOMUC, a multinational contingent of about 380 military personnel from Congo, Gabon and Chad, mandated by CEMAC, the Economic and Monetary Union of Central Africa;
- Fifty South African military personnel, present as a result of a bilateral agreement between the two governments, intended to support the reform of the Presidential Guard; and
- EUFOR – a European force created following Security Council resolution 1778 (2007) in response to concerns about the regional implications of the Darfur conflict. The troops have started to be deployed to the areas bordering Sudan and Chad, where they will be based in the town of Birao. The force is intended to have a final strength of 3,700. Its mandate is to protect civilians and to facilitate humanitarian assistance and personnel.

At the same time, there has been an increase in the number of international humanitarian NGOs from 3 in July 2006<sup>20</sup> to 35 by the end of 2007, some of which have successfully managed to negotiate operations behind rebel-held lines. These organisations have helped provide basic health services to the local population following the almost-complete collapse of the state health system. Frequently this means paying staff bonuses above the national salary scale in order to provide the necessary incentive. It has also meant that emergency-affected populations are receiving free consultations in certain circumstances. Their presence has led to an improvement in

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<sup>18</sup> CAR: Our daughters have no future, IRIN Humanitarian News and Analysis, accessed at [www.irinnews.org/PrintReport.aspx?ReportId=78233](http://www.irinnews.org/PrintReport.aspx?ReportId=78233) on 19/5/08.

<sup>19</sup> IDI with the President of RECAPEV.

<sup>20</sup> CAR: Cornered in the Centre, Humanitarian and Development Partnership Team CAR, powerpoint presentation, January 2008.

vaccination coverage for infants so that over 80%, are now fully vaccinated (as opposed to 32% at the time of the MICS survey in 2003). Likewise, the coordinating mechanisms that have been established enabled a rapid and effective response to the meningitis outbreak in Kaga Bandaro in February 2008<sup>21</sup>.

In an effort to provide education for displaced children, UNICEF has developed a programme to rehabilitate schools, provide materials and to recruit and train parents in basic teaching skills so that they can compensate for the lack of regular teachers. In addition, the humanitarian community has been responsible for, among other things, distributing food aid to 210,000 people and seeds to more than 45,000 families, rehabilitating water supply systems, as well as managing to establish effective mechanisms for the coordination of their activities under the auspices of the UN's Office for the Coordination of Humanitarian Aid (OCHA).

With OCHA's backing, a Consolidated Appeal for 2008 has been prepared for a total value of \$94.3 million, incorporating actions planned by NGOs and members of the UN system. It is aimed at assisting 1 million people. As of 15 May 2008, 36% of this amount had been funded (but only 7% or \$1.6m in the health sector, which includes HIV and responses to SGBV)<sup>22</sup>. A similar appeal was put together in 2007 and raised \$81 million<sup>23</sup>.

## 4.2 How was HIV addressed in the emergency response?

Generally, HIV has not been prioritised in the course of the response to the humanitarian emergency, although there are some notable exceptions. The World Food Programme (WFP), for instance, has identified PLHIV and orphans and vulnerable children (OVC) as among the most vulnerable and has included them as target groups for its food distribution programme. The IRC launched a comprehensive programme including PTMCT, a secure blood supply, treatment for STIs, VCT, ARV, condom distribution and awareness-raising in their area of operation. Part of their efforts have focused on the FACA and the rebels. In the 2007 Consolidated Appeal, HIV was included as one of the objectives in the health sector and a certain number of activities in the field of prevention were carried out. As a result, 10,225 people participated in VCT activities, 1697 peer educators and 1948 community agents in conflict areas were trained in HIV/STIs, and UNFPA distributed 1.4 million condoms (OCHA, 2008 p. 9).

Five priority areas are identified in the Consolidated Appeal for 2008 (protection; health; shelter and non-food items; food security; water; sanitation and hygiene) together with 3 strategic priorities (enhancing protection of affected populations; provision of life-saving assistance; linking humanitarian assistance, early recovery and development). HIV is therefore not singled out as a priority, although one of the 5 objectives listed for the health sector concerns strengthening the response to STIs and HIV/AIDS, including support for vulnerable and at-risk groups. Those at risk groups include: victims of sexual abuse, PLHIV, IDPs, refugees, adolescents, pregnant women, and men/women in uniform. Among the priority needs identified is improved access to HIV/STI prevention services, including VCT, secure blood supply, and decentralisation of PMTCT and ARVs in the regions affected by conflict. However, there is no clear strategy that has been defined for implementing this area of work, which instead is dependent on individual NGOs to implement at a project level.

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<sup>21</sup> Even though humanitarian organisations have been able to use their status to negotiate access to vulnerable populations in areas under rebel control, they are still not able to reach all areas. Mobile clinics organised by MSF near Batangafo and Markounda, for instance, had to be suspended because of insecurity as of January 2008 (SIDA/SRSA Donor Mission to the North West, 11-15 January 2008).

<sup>22</sup> Only one other project, an FAO initiative aimed at improving food security for HIV/AIDS affected households, specifically aimed at addressing HIV-related needs, is included in the appeal outside the health sector.

<sup>23</sup> Financial Tracking Service consulted on Relief Web at [http://ocha.unog.ch/fts2/pageloader.aspx?page=search-reporting\\_display&CQ=cq100608214713LNY1eCV9Fd&orderby=Decision\\_Date&showDetails=1](http://ocha.unog.ch/fts2/pageloader.aspx?page=search-reporting_display&CQ=cq100608214713LNY1eCV9Fd&orderby=Decision_Date&showDetails=1) on 10 June 2008.

Importantly, however, the appeal does give considerable importance to the issue of SGBV, including the provision of PEP kits, but again, these projects remain almost completely unfunded at the time of writing.

Despite the existence of a number of projects that include HIV as part of the appeal, the fact that the epidemic is not made a sectoral priority is likely to mean that there is no regular monitoring of the extent to which HIV-related interventions are actually being implemented. Given the factors identified in this report pointing to the risk that HIV could increase sharply in CAR, this omission is potentially serious. Although other immediate needs may seem to merit more urgent attention, the consequences of the relative down-playing of the risks of HIV transmission in the face of these competing priorities could have very costly consequences for the country in the future both in terms of the loss of human life, reduced productivity and the increased health burden.

A rapid analysis of the content of the appeals that do address HIV shows that, to the extent that HIV is included as a concern, the majority of projects choose to address the epidemic through IEC rather than more fundamental preventive interventions, such as condom distribution. Despite prevalence rates of more than 7% in emergency-affected areas, almost no attention is given to the specific needs of PLHIV. Moreover, free condom distribution – one of the cheapest and most effective ways of preventing the spread of HIV – is left to UNFPA through its regular channels despite the large unmet demand clearly identified during the course of this study (see section 3.4 above). Other institutions need to get involved urgently with condom supply in order to help bridge the shortfall in supply.

Four out of 26 projects in the health section of the appeal<sup>24</sup>, (representing 12.4% of the total figure for health, i.e. a total value of \$2.9m), address HIV as a central focus, with a further 7 including the illness in a significant way and 3 in a minor way. However, it is important to note that as of 15 May 2008, none of the 4 HIV projects had received any funding.

## 5. The effects of the emergency

### 5.1 On vulnerable groups

#### 5.1.1 How, why and who has become more vulnerable to HIV infection?

##### 5.1.1.1 Victims of sexual violence

The various episodes of violence that have characterised CAR's recent history have been marked by repeated incidents of rape and SGBV. Although sexual violence seems to be more intense in certain areas and at certain periods, it has, at times, reached alarmingly high levels. Inevitably, this is a factor that favours the transmission of HIV.

In the document justifying its decision to open an investigation into the situation in the country, the International Criminal Court (ICC) refers to sexual violence as having been a 'central feature of the conflict'. It has received credible reports of at least 600 rapes over the 2002-03 period, while acknowledging that this number is likely to under-represent the true figure. At that time, Congolese troops led by Jean-Pierre Bemba, known as the *banyamulenges*, committed widespread rape in areas such as Bangui, Bouar, Bossangoua and Bozoum. In many instances, the offences are said to have been committed with aggravating circumstances (collective rape, forced incest, the use of harmful objects, etc) and have resulted in the stigmatisation of the victims, as well as HIV infection<sup>25</sup>.

An investigation into the same events conducted in 2006 (Koudounguer R. Et al, 2006) comes to a similar conclusion and argues for survivors to be given access to the full range of medical care

<sup>24</sup> Respectively CAF-08/H10, H11, H12 and H15

<sup>25</sup> ICC-OTP-BN-20070522-220-A\_EN, *Background: Situation in the Central African Republic, Overview*, ICC, 22 May 2007.

and attention. The prejudice and shame surrounding rape even in a conflict situation means that women are reluctant to come forward and it becomes harder to identify or assist such cases. Most of the women interviewed in the study<sup>26</sup> had not had HIV tests because of fear of stigmatisation, lack of financial means or ignorance. Since that period, they developed psychological problems and lost their livelihoods, while 17% were repudiated by their husbands, leading to the break-up of their family. However, in some parts of the country, notably in Bangui and Bossangoua, rape-survivor groups have been formed and have been able to advocate successfully for support for their members.

More recently, reports of widespread rape have once again been received. OCHA suggests that over 15% of women and girls in the north of the country have been subject to SGBV<sup>27</sup>. This threat seems to be one reason why IDPs are forced to leave their homes, since women and girls are extremely vulnerable to attack whilst carrying out household duties such as fetching water and firewood. A number of NGOs, including the International Rescue Committee (IRC) have initiated activities to address what has been identified as a significant problem. In a 7-month period, using a system of referral by community leaders, IRC received 1300 cases of SGBV (including about 20 cases of men and several cases of children as young as 4) in an area concentrated along a 50-km stretch of road. They offer treatment for victims, including PEP, although in only 3-4% of cases women come forward within the 72 hours within which the necessary prophylaxis can be administered<sup>28</sup>.

More generally, PEP kits for the treatment of rape patients are not widely available, although they have been made available in certain areas (e.g. Paoua). These supplies can be made available through UNFPA, which distributes them to NGOs with whom they have a contract. As they are perishable, however, only 8 are kept in stock at any one time, a quantity which the local staff feel is insufficient (the kits are also used for medical personnel where required). Further supplies can be air-lifted in, but given the apparent scale of the need, alternative strategies that permit a more flexible response are needed.

#### **5.1.1.2 Commercial sex workers**

The field work for this study lends support to the hypothesis that commercial sex work is becoming more common. PLHIV in Bouar clearly identified that the deteriorating economic situation as a factor which is pushing young women and girls into adopting behaviour that puts them at risk of HIV. According to them, young women sometimes even have parental encouragement if it is felt that this will help bring in extra resources to help support the family. In other cases, they claimed, parents have lost the authority to control rash behaviour because children no longer respect their parents because they can no longer provide for their families. Corroboration of this trend is found from a variety of sources. Another key informant suggested that OVC are particularly at risk of becoming involved with sex work.

The sex workers (known locally as *filles libres*) who participated in the focus group in Bouar explained how economic difficulties caused by the conflict and insecurity have created further problems for them. With the exception of the armed forces, men locally have less money available and more women are becoming involved with sex work (especially IDPs who are particularly vulnerable, especially those in female-headed households), a finding that was confirmed by the Inter-agency Mission, particularly in Kaga-Bandoro. This situation has caused hardship for existing CSWs, with one consequence being that they cannot always send their children to school. In the face of declining incomes, one of them claimed that they are more likely to accept unprotected sexual relations since a client may offer twice or more the regular fee<sup>29</sup>. Similarly, UNDP (2006)

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<sup>26</sup> In this case all were women, although some cases of male rape have also been reported.

<sup>27</sup> One key informant suggested that such statistics should be treated with caution since they are not backed by scientific studies.

<sup>28</sup> IDI with IRC Medial Coordinator.

<sup>29</sup> Whereas in a 2001 study cited in UNDP (2006), sex workers were using condoms in 75% of sexual transactions.

suggests that women that have more recently become involved with commercial sex are likely to be more reluctant to use condoms for fear of being branded a prostitute.

In this context, the presence of uniformed personnel, and particularly the foreign troops, is significant. The *filles libres* in Bouar were unambiguous in stating that the presence of the South African troops in the vicinity has increased sex work and that young women are attracted to their camps. Members of the Inter-agency mission reported that in Bozoum the presence of FACA/FOMUC is even causing some *filles libres* to leave Bangui for the town<sup>30</sup>.

### 5.1.1.3 Internally displaced persons (IDPs) and the local host population

Just over half of the IDPs are female, and half are under the age of 15 (OCHA/UNFPA, 2007). Most are illiterate. Despite the fact that IDPs generally manage to stay together as a family unit, a number of women interviewed had either lost their husbands or taken refuge without them. Widows/abandoned women, should be considered a particularly vulnerable sub-group, although little data seems to exist about them in particular. Elderly and handicapped people are sometimes left behind in the original villages. No information about their particular situation has been identified but without the normal support mechanisms they can be presumed to be living in a very precarious state (OCHA, 2008 p.20)

Although a recent study did not find any significant difference in the status of the IDPs and the local host population (OCHA/UNFPA, 2007) (60% of all children in the areas surveyed had not been to school over the past year, largely because of a lack of funds, inaccessibility or insecurity), the IDPs interviewed in Bouar (all women) indicated that their living conditions have deteriorated in many ways. During their flight, some women gave birth in the bush, while others suffered miscarriages or sudden deaths, as well as malaria and coughs. Other changes in their lifestyles that potentially make them more vulnerable to HIV include:

- Whereas they used to farm their own fields, they now they hire themselves out as daily labour for a few days a month, for which they are paid 250-500 CFA (approx. \$0.55 - 1.10) per day.
- Previously, children received food aid via the school feeding programme, but now the whole family is dependent on these rations.
- They become sick but cannot afford medicines: 'since we have been here, we get sick but we can't afford to buy the medicines'. All they have available is paracetamol bought at the market or traditional remedies.
- Their children used to go to school, now not all of them do<sup>31</sup>. One woman said 'I am very worried about my children's school. It makes me sad to see them at home.'
- Whereas they used to sleep on beds, now they sleep on the floor on sacks or cardboard. They also lack clothes, cooking utensils, etc.
- They no longer have access to latrines and have difficulty in finding water.

Such conditions are likely to either make these women more susceptible to HIV by reducing their levels of immunity to illness or will push them into risky behaviour of the kind described in the previous section. Those that are already HIV positive will find themselves less resistant to the disease. The local host population is also made more vulnerable to HIV in similar ways because of the increased cost of living that has been caused by the breakdown of the commercial network in the country and the arrival of IDPs.

<sup>30</sup> Verbal debriefing, 10/3/08.

<sup>31</sup> This was not the case for most of the Mbororo women, however, whose children had never gone to school.

#### **5.1.1.4 Uniformed personnel**

The case of uniformed personnel is particularly significant in the framework of this report. UNFPA cites the HIV-prevalence rate among uniformed services to be 21%<sup>32</sup>, an alarmingly high figure which was confirmed when the medical officer at the barracks in Bouar informed the research team that 60 out of the 150 men stationed there have been tested and found HIV positive (40%). According to this same source, condoms are made available to the men in their kits and are also sold at the pharmacy but the quantity is insufficient and there are stock interruptions. Given the fact that these men are likely to be stationed away from home over considerable periods (a situation which is likely to lead to contact with sex workers), be exposed to stress and have access to cash, while at the same time exerting a level of influence over the local population, this creates a potentially risky situation.

#### **5.1.1.5 Ex-rebel combatants**

In Bouar, the research team came across a group of 500 ex-rebel combatants who have surrendered themselves to the local military commander but have not yet been incorporated into a formal DDR (disarmament, demobilisation and reintegration) programme. They are surviving without any source of income through doing odd jobs for the local population, who tend to view them with suspicion (one is said to have been responsible for raping a local girl). That the ex-combatants are hungry is indicated by the fact that they regularly attend food distributions organised by WFP in Bouar and seek to benefit from the rations, even though they do not qualify under current criteria. Among them are a group of 17 women (5 pregnant) who, according to the army doctor, all show symptoms of STIs. In a small focus group discussion, these women explained that they are living in very difficult conditions. They sleep on the floor and have no personal items such as soap or sanitary towels.

The women had received information about HIV through MSF. At least one of them admitted to having serious health problems and said she would like to be tested for HIV. She thinks quite a lot of her fellows are infected and said she would like to be able to help them. The women explained that they need to have access to condoms but that they are not made available. They can be bought locally but, one of them asked, 'if we use the little money we have to buy condoms, what would we do to eat?'

At the time of the field visit, the local commanding officer said that there was no DDR programme for this group, and that he had no resources at his disposition to look after them. This makes them vulnerable in a similar way to IDPs, since they are hungry and may be forced to adopt atypical behaviour in order to survive (eg. sex work), particularly since they currently receive no targeted relief.

#### **5.1.1.6 Children and OVC**

There is insufficient information available about the impact of the emergency on children and OVCs in particular. Members of the Inter-agency mission suggest that OVC are taken in by host families but that they are in precarious situations (e.g. sleeping on verandas). They get by doing odd jobs for the families concerned. According to the head of Ede Biro In Sida, a local NGO in Bouar which supports OCV, however, there has been no major change in the situation of the children his organisation works with over the last 2 years despite the influx of IDPs. Less than half of the children accompanied are in school, and where these children cannot attend school it is unlikely that the other children in the host family will go either so that serious discrimination does not take place.

### **5.1.2 Resilience: how have these vulnerable groups coped with the emergency?**

The most widespread response to the various security threats has been for large numbers of people to seek refuge in the bush, in neighbouring towns or to cross over into neighbouring

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<sup>32</sup> United Nations, Central African Republic Consolidated Appeal: Projects 2008.

countries). Despite these coping strategies, food security has been affected by the conflict. The Inter-agency mission found that whereas before people were eating 2-3 meals a day, now they are eating only one. As confirmed by the WFP/UNICEF study (2007), both the quality and quantity of people's diets has been affected. There tends to be little diversity in food intake, with people eating mainly tubers and few cereals or meat.

Those in the bush tend to stay relatively close to their original villages, gravitating to the outlying fields where they previously worked for just a few weeks a year. In such conditions, they try to survive on a subsistence basis but have virtually no access to schools, health services, clean water or other basic services. Because they are dispersed, they are hard to reach, even by the humanitarian community that may be able to operate within areas under rebel control. There is only one example of a camp for IDPs in CAR, where over 5000 people are living in make-shift shelters in the town of Kabo near the border with Chad.

IDPs in towns are in a slightly less precarious situation. In most cases, they manage to find a host family or rent a house and find casual work carrying out agricultural labour or doing odd jobs, such as thatching roves or selling doughnuts or peanut oil in the local market. They may even find land to farm, providing they have a means of accessing seeds and tools. Most importantly, they are within relatively easy reach of certain services and can more easily obtain humanitarian assistance. Nonetheless, they do not necessarily have access to cash that will enable them to pay for health or other services and food rations are said to be insufficient<sup>33</sup>.

IDPs are often uncertain about the safest place for their families, causing them to move frequently between the bush, their fields, local towns and their villages. Some have moved to and from their home villages on several occasions and most would wish to return home when the security situation permits. The result is that there are sometimes population movements in both directions at the same time. In February 08, for instance, an estimated 10,000 people left one area while at the same time another 2,000 returned there<sup>34</sup>.

## 5.2 On people living with HIV

### 5.2.1 Vulnerability: how has the emergency affected existing vulnerabilities?

A large majority of PLHIV households are headed by women (80%) and have a disproportionate number of dependents due to the presence of OVC. PLHIV tend to suffer from greater poverty than households that are not affected (poverty rates of 72% and 68 % respectively, UNDP 2005) due to the fact that they have to cope with increased health costs and reduced income, prompting them to sell off productive assets in order to survive. The same report shows that the increased risk of poverty is even greater for those households that have taken in OVCs. A recent WFP study (WFP 2007) found that 22% of PLHIV households in Bangui suffer from food insecurity (7% severely and a further 17% moderately). PLHIV met in Bouar described how their food intake has deteriorated over the recent period. "Before we ate well, but now we eat with great difficulty. It's difficult to get enough. We haven't got enough money". They complained that both the quantity and quality of the WFP rations has deteriorated. There used to be tins of sardines, for instance, but these are no longer available and FGD participants claimed that the flour is of poor quality).

Access to ARVs is only very recently becoming a reality for many PLHIV in CAR. They are still far from widely available, particularly for those in more remote rural areas who are unlikely to have had the opportunity even to determine their status. There have been severe difficulties in introducing planned facilities in areas affected by conflict, particularly due to the lack of trained personnel willing to work in these regions given the risks involved. Moreover, even in some areas where ARVs are available, supply problems can occur. The network of PLHIV in Bossangoa reported that there have been interruptions in ARV supplies and prophylactic antibiotics - a fact

<sup>33</sup> A male IDP interviewed by the Inter-Agency Mission referred to above in Kabo said that 'the rations are very low when compared to our needs'.

<sup>34</sup> IDI with Head of OCHA.

which was confirmed by a visiting delegation - and that there is still a high mortality rate among their members.

The existing cost-recovery policy means that ARVs as well as treatment for STIs and OIs must be paid for. ARVs cost 2000 CFA per month (\$5) although they are issued free for students, sex workers, military personnel, health workers and anyone who the administering doctor considers to be extremely poor. According to focus group participants, the imposition of such fees prevents them from seeking appropriate health care. The participants in the PLHIV focus group held in Bouar described their inability to access services at the hospital as a result. This was not such a problem prior to the outbreak of the conflict, since in those days it was possible to make a living by selling produce that they grew in their fields. Nowadays, agricultural production is much more difficult and incomes have fallen significantly.

Moreover, in order to obtain their supplies of ARVs, high transport costs are sometimes incurred to reach the distribution centre with no reimbursement made. According to the President of RECAPEV, this has led to some cases of abandoning ART given the prohibitive costs. In other cases, people have abandoned treatment because they have been unable to reach the facilities due to conflict and insecurity.

There is no evidence of an increase in stigma or discrimination as a result of the emergency situation. PLHIV point to a degree of stigmatisation generally, irrespective of the conflict, although at least some of them say that when their families are better informed about the illness they are more accepting of their HIV positive relatives.

### **5.2.2 Resilience: how have PLHIV coped**

In the face of the deteriorating economic environment caused by the country's prolonged instability, PLHIV have been obliged to respond to their increasing hardship by foregoing certain basic entitlements. Such restrictions are likely to jeopardise their well-being even further over the longer-term. According to the WFP/UNICEF study (2007), PLHIV in Bangui have adopted three main coping strategies: reducing the amount of food they eat (which tends not to include any animal produce), getting into debt, or begging. Many are eligible for food aid from WFP but FGD participants said that they sometimes resort to selling these supplies in order to afford the drugs and other basic supplies such as soap, a move that would seem to negate the purpose of providing food aid<sup>35</sup>. Moreover, in some cases, some poorly-trained health agents cease issuing rations to those who appear to be in good health or who have gained weight<sup>36</sup>.

Given the current user fees imposed as part of the official cost-recovery policy, PLHIV are also forced to miss out on treatment when they are ill. One PLHIV in Bouar explained that 'when we're seriously ill, we can't afford to go to hospital'. Given that many PLHIV have a reduced income-generating potential, a higher than average number of dependents in their households and are among the poorest and most vulnerable, it is unrealistic to ask for them to have to pay for treatment. The PLHIV met in the course of the field work also pointed to the fact that nowadays they have greater difficulty sending their children to school; some are sent home because their parents cannot pay the school fees.

No formal system of HBC has been developed as yet in CAR, although informal mutual support mechanisms between PLHIV do operate. A loose network of associations of PLHIV, RECAPEV, does exist and has been given an official role in the National Strategic Plan for providing support and counselling for PLHIV. The plan also envisages providing help with the nutrition and economic activities of PLHIV. As a result, members of the associations are able to gain access to market gardening, micro-credit or other forms of income-generating activities.

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<sup>35</sup> It is worth noting, however, that in a personal conversation, the WFP Country Director in CAR offered the opinion that this is a legitimate use of food aid

<sup>36</sup> IDI with President of RECAPEV.

## 5.3 On service provision

### 5.3.1 Health services

The low international profile given to the protracted crisis in CAR and donor concerns about poor governance have combined to prevent the country from receiving international support in its fight against HIV despite the high level of prevalence and the difficulties posed by the conflict and insecurity. This lack of secure funding, combined with weak local capacity, have prevented widespread access to ARVs and other essential HIV services from being put in place. The National Strategy for the Fight against HIV/AIDS (CNLS, 2006) also notes that an initially effective epidemiological surveillance system has been negatively affected by the conflict and instability and must be built up again.

While access to preventive services and treatment is slowly improving, insecurity has further discouraged medical staff from working in large areas of the country. An MSF nurse was killed by rebels in mid-2007, while in early 2008, a local doctor working in Baboua in Nana Mambere was kidnapped, ill-treated and held for 3 months. He has now left the service and so far, it has not proved possible to replace him. The hardship and fear associated with postings in the north of the country have deterred health professionals from accepting work in such areas, except where significant bonus payments are made by NGOs. Almost all the midwives are concentrated in Bangui, with none in certain major towns in the conflict-affected north, such as Kaga-Bandoro. The lack of qualified personnel is a severe constraint in implementing treatment programmes for PLHIV. In Bouar, for instance, the research team found that if the relevant doctor is not present, people cannot receive their medicines on time since he is the only one able to carry out this function.

The conflict has also led to the widespread destruction of health centres, leaving many out of action. UNICEF says that one third of the 900 health centres in CAR are reported to be non-functional after being looted or falling into neglect as a result of the emergency<sup>37</sup>. In Nana Mambere, for instance, of the 44 health centres in the prefecture, only 36 are functional today (although the areas where they no longer operate also coincides with those where the majority of the population has fled). Now that livestock owners, once the main target for the *coupeurs de route*, or highwaymen, have largely fled the area, health workers have become a particular focus for bandits who try to get hold of the funds held by the management committees.

Falling incomes have reduced people's ability to access basic health care even when it is available because the cost is becoming increasingly prohibitive. Instead, people turn to street sellers, with the result that the doctor in charge of the hospital in Bouar claimed that 'we just end up dealing with the complications'.

Largely as a result of this situation of uncertainty and insecurity, roll-out of nation-wide VCT, PTMCT and ARV services has been delayed, with the northern conflict-afflicted and remote eastern regions worst affected by the slow pace of implementation. Above all, the conflict has deterred trained staff from accepting postings to the areas concerned, while security issues also give rise to logistical problems and make adequate supervision more difficult. The staff at the VCT centre in Bouar, for instance, explained that they have to travel to fetch the reagents needed to carry out HIV tests themselves. Hospital staff in the same town report encountering interruptions in supplies of the drugs for treatment of OIs and STIs, a situation also met by the recent Inter-agency Mission in Kabo, a town of 41,000 and the site of CAR's only refugee camp<sup>38</sup>, where no treatment for OIs was available.

Nationally, there are currently 32 centres able to provide ARVs, of which 20 are in the capital, Bangui. Nonetheless, the drugs are far from universally available and the numbers receiving treatment are sometimes small. In Bozoum, for instance, where the centre has only recently

<sup>37</sup> UNICEF, (undated), *A Cry from the Health: Central African Republic*, p.11.

<sup>38</sup> Mission Inter-agences, 2008, *Evaluation Rapide de la situation des personnes déplacées internes et le VIH en République Centrafricaine : Rapport de Mission*.

started operating, only about 20 people were on ARVs out of a total of 157 cases being monitored by the hospital in late February 2008<sup>39</sup>. Overall, of the estimated 40,000 PLHIV in CAR who would be eligible for such treatment, only 8,208 adults and 386 children are receiving these drugs at present<sup>40</sup>, although the target is to increase this number to 15,000, (i.e. 37.5% of those needing the drugs) under the 7<sup>th</sup> round of the Global Fund. Among the constraints are the lack of trained personnel who can prescribe ARVs and who are willing to be based in conflict-affected areas (in Bouar, for instance, it appears that people on ARVs cannot receive their medicines on time if the relevant doctor is not present since he has no trained replacement), a weak procurement system that can lead to wastage, and drug stock outs.

The situation with regard to VCT centres is barely more advanced. At the time the research for this report was carried out, 8 out of 16 VCT centres were still not in operation, although the remainder – with the notable exception of Birao, in the conflict-affected prefecture of Vakaga, close to the border with Chad and Sudan – have since opened. This number is still too low to make the facilities accessible to a large portion of the population given the distances and serious transport problems faced by people in rural areas. Ultimately, it is intended to extend the services to the sub-prefecture level but the research team was unable to obtain a date for when this is likely to become a reality.

In terms of mother-to-child transmission the picture is no more reassuring. Rates of mother-to-child transmission are high (up to 35% when there is no external intervention, UNDP, 2006). A PMTCT programme that receives support from UNICEF exists which has trained midwives and started to put in place the necessary facilities. These services are available in some conflict-affected areas, e.g. Bozoum and Kaga-Bandoro, but not, according to the findings of the Inter-agency mission, in others (e.g. Paoua, Kabo). Overall, the number of pregnant women receiving the necessary drugs is increasing, but nonetheless remained very low in 2007. Out of a total of 44,505 pre-natal consultations at state-run health facilities last year, 4389 women agreed to undergo an HIV test, although in reality only 3,485 such tests were carried out<sup>41</sup>. Of these, 2685 positive results were recorded but only 937 women actually received Nevirapine during their delivery<sup>42</sup>. The reasons for the high drop-out rate at each stage are not known and need to be studied in more detail. It has been suggested that women who test positive tend to change health centres in order that their status should not become known<sup>43</sup>. It is possible that displacement could be another reason why some women are unable to return for treatment, although no such cases were encountered during the field work for this study.

IEC/BCC activities are still carried out by both state and non-governmental bodies in conflict-affected areas but, particularly in the case of the former, have had to be curtailed. In other cases, pre-existing programmes have been scaled down, as is illustrated by the case of a group of peer educators in Kaga-Bandoro cited by the Inter-Agency Mission who have been forced to abandon their activities as a result of the insecurity. The Mission found programmes for young people in 2 out of the 4 areas visited, although none were targeted at sex workers or homosexuals. It is worth noting that the CSWs in Bouar expressed the need for more information targeted at women such as themselves.

While many of the participants in the focus groups understood the importance of using condoms (often through having heard messages on the radio), they did not readily have access to them. There is a severe shortage of condoms in many parts of the north (e.g. Bouar, Kabo) and in many areas, condoms are simply not available at all, particularly those that are available free of charge. One female IDP taking part in the FGD in Bouar claimed never to have seen a condom. This lack

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<sup>39</sup> Ditto

<sup>40</sup> 'Rapport de mission de collecte des données dans les sites de traitement ARV de Bangui et de province', June 2008

<sup>41</sup> Personal correspondence with Maxime Biampeng, HIV Focal Point for UNCHR based on the 'Rapport de mission de collecte des données dans les sites de traitement ARV de Bangui et de province', June 2008

<sup>42</sup> Ditto

<sup>43</sup> Ditto

of availability would seem to be partly due to problems in the organisation of the supply chain generally, but is made worse by the conflict. PSI conducts social marketing of condoms in 40 out of 69 sub-prefectures in the country, but largely fails to cover those areas where access is made more difficult by the prevailing insecurity<sup>44</sup>.

In such circumstances, efforts to raise awareness about how people can protect themselves from HIV are likely to be less effective. The VCT centre in Bouar visibly carried a message about adopting the ABC technique to protect against AIDS. Unfortunately, the centre had had no free condoms available for distribution since October 2007. PSI does have a presence in the area, but various groups, including IDPs, claimed that they could not afford the cost, however minimal. The Inter-agency mission found no condom distribution programme in 2 of the sites visited, with a PSI-sponsored programme (which can be assumed not to be accessible to some of the most vulnerable sectors of the local population) in the two others. There is no official channel for making condoms available to the rebel groups but some NGOs have carried out HIV prevention work in rebel-held areas and UNFPA staff reported having heard that young boys sometimes come to fetch them on behalf of the rebels.

Secure blood supplies remain a challenge in most of CAR, with the exception of Bangui, where the only blood bank is based. In most of the provincial hospitals, blood is supplied by family members and is screened before being used but the amount made available in this way is very small (5000 bags in 2004, UNDP 2005). Moreover, essential hospital supplies such as surgical gloves are not always available (UNDP, 2006). The doctors in Bouar say that they have to buy their own gloves in order to ensure that they are protected.

### 5.3.2 Other basic services: education, sanitation, water

Most basic indicators in the Central African Republic are at alarming levels, placing them among the worst in the world, and many of them have shown a marked deterioration over the past 15-20 years. This is reflected in the fact that the country is ranked 171 out of 177 countries in UNDP's Human Development Index 2007/2008. There is a serious lack of almost all basic infrastructures (drinking water, roads, electricity, etc). For example, only 40% of the population have access to safe drinking water, and 4.8% to adequate sanitation facilities (UNDP, 2006).

The prevailing violence and insecurity has destroyed the already limited social and productive infrastructure, forcing many people into growing poverty and a return to a subsistence economy. Between 1980 and 2005, real per capita income fell by 32% to become the lowest in the Central African region (UNDP, 2006), while the incidence of poverty increased from 62% in 1994 to 67% in 2007 (WFP/UNICEF, 2007). Unsurprisingly, food security is also becoming a serious problem - 22 % of rural households in CAR are food insecure: 7% severely and 15% moderately (although rates of child malnutrition are not yet considered to be at emergency levels) (WFP, 2007); with female-headed households more likely to be food insecure than male headed households. The highest levels of food insecurity were found in Ouham Pende (39%) and Nana Gribizi (23%)<sup>45</sup>.

Education has also been severely affected by the humanitarian crisis. The gross school enrolment rate has fallen from 76.5% in 1988 to 68.7% in 2003 (UNDP, 2006) as a result of problems related to costs, insecurity and distance. This situation tends to penalise girls in particular, since their enrolment rates are significantly lower than for boys (net primary enrolment rates for boys stands at 55.8% as opposed to 46.7% for girls, MICS 2006<sup>46</sup>). The conflict has led to schools being destroyed and teachers fleeing the affected areas. UNICEF estimates that 55,000 wooden benches have been looted from schools in the north in order to be used as fuel by rebels and

<sup>44</sup> Evaluation rapide de la situation des personnes déplacées internes et le VIH en République Centrafricaine : Rapport de Mission, p.11.

<sup>45</sup> Traditionally, both these prefectures produce a surplus of maize and cassava, but with the collapse of production as a result of the conflict and insecurity, this situation has been reversed.

<sup>46</sup> The disparity is significantly higher in rural than in urban areas.

IDPs<sup>47</sup>. Consequently, primary school enrolment in 2006 – a year in which the armed conflict was at its height - was half that of the previous year (only 30.7% as opposed to 70% in 2005<sup>48</sup>).

Water and sanitation services have been among the casualties of the conflict in CAR. In Bouar, the water system has been out of repair for two years since the water distribution company ceased to channel any piped water. As a result, the hospital is without a water supply and had to use water from a borehole that is kept in basins in the birthing room. The people of the town must rely either on one of two public boreholes, for which they must pay 50 CFA (not including any transport costs), or draw water from unclean wells. The Inter-agency mission also described pumps having been destroyed during the fighting, while IDPs in the bush have been forced to use contaminated sources after leaving their villages. As a result, IDPs are made more vulnerable to malaria and other environmentally-linked illnesses and are likely to suffer from reduced immunity to illness that can make them more vulnerable to HIV.

## 6. Key Findings and recommendations

### 6.1 Key findings

- The roll-out of VCT centres, PMTCT facilities and distribution of ARVs has been slow, at least partly due to the difficulty in posting staff to remote rural areas suffering from conflict and insecurity. Where HIV services do exist, it is partly thanks to NGOs who make additional salary payments, but the state does not have funds to make similar incentive payments. The existing level of provision is not sufficient to enable much of the rural population to have access to HIV prevention and care services.
- The cumulative effect of the multiple crises in CAR has been to stifle production and internal trade, crippling the rural economy and rendering large sections of the population significantly more vulnerable. Among them are IDPs, PLHIV, CSWs and some ex-combatants. The reduced level of internal commerce, however, is likely to have reduced the level of exposure of transport workers, one group previously considered to be at high risk of exposure to HIV, although no direct evidence seems to be available to this effect.
- The conflict and insecurity has had a serious impact on the capacity of these vulnerable groups to contribute towards the costs of health care. This means that the cost-recovery policy currently applied, which includes drugs for STIs and OIs, often prevents them from having access to appropriate care and treatment.
- HIV interventions have tended to be side-lined in favour of immediate life-saving measures pending an improvement in the security situation. While protection measures are clearly essential in order to deliver adequate services, HIV needs to be tackled in parallel with humanitarian efforts and not left until a later stage. The conditions for an explosion of the epidemic exist (health system close to collapse, displacement, basic prevention and treatment measures not in place). While other more visible priorities are absorbing much of the efforts of the humanitarian community, HIV is almost certainly spreading rapidly. It is therefore not a question of dealing with one issue before tackling another, but of looking at how a minimal but effective response can be mounted in parallel with other efforts.

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<sup>47</sup> UNICEF, (undated), A Cry from the Health: Central African Republic, p.21.

<sup>48</sup> Half the number of children were in primary education in 2007 when compared with the pre-conflict period. OCHA (2008) estimates that only 21.4% of children in 5 conflict affected prefectures were actually able to attend school in that year.

- Demand for condoms far outstrips their availability. Whereas sufficient awareness of the importance of using condoms seems to have created an interest, their lack of availability is restricting their take-up. Groups such as IDPs and other poorer sections of the population cannot afford to use their scarce cash to purchase condoms. Targeted distribution of free condoms is therefore a crucial and cost-effective step towards halting the spread of HIV.
- No specific provision appears to have been made for targeting HIV positive IDPs, including those who do not know their status. Those in the Kabo refugee camp or attending distributions of humanitarian aid are an easy target group who could be the focus for IEC/BCC as well as VCT. The particular needs of this sub-group – and in particular the fact that they may shortly be returning home to areas where access to ARVs will be more difficult – should be taken into account and planned for.
- Despite the existence of widespread and repeated incidents of rape, PEP kits are not readily available in most parts of the country. While UNFPA can supply these with relatively short notice and there are constraints linked to the perishable nature of the supplies, given the importance of administering the treatment in a 72-hour period, it would seem probable that women are being denied treatment because such kits are not readily available.
- There are indications that ex-combatants who have been demobilised but have not been integrated into a formal reintegration programme - such as those met in Bouar - are seriously affected by HIV (e.g. high levels of STIs). They are living in extremely precarious conditions and, as such should be considered a particularly vulnerable group for whom a programme should be developed.
- There are credible reports to indicate that the presence of international peace-keeping troops is leading to an increase in commercial sex work. No information was obtained about the extent to which HIV is taken into consideration by peace-keeping missions. However, such practices compromise efforts to control HIV both in CAR and in the sending nation. It is imperative that the issue is taken very seriously by military authorities and the international bodies overseeing their missions.
- There is a dearth of qualitative information about HIV-related services and PLHIV in CAR. A better understanding of how different groups are likely to be affected by the disease is necessary in order to tailor responses appropriately, not least IDPs.

## 6.2 Recommendations

- Widespread distribution of free condoms must be considered an urgent and absolute priority. Various means of distribution can be considered, such as including them as a routine item in all hygiene kits that are distributed, or in parallel with food distributions. Information about correct condom use should also be provided on these same occasions. Attention should be given to ensuring that military personnel are given access to condoms at all times.
- Opening of the remaining VCT centre in Birao should be seen as a key priority, while more detailed plans and targets need to be developed for extending the roll-out of ARV, VCT and PMTCT services to the sub-prefecture level. Adequate resources will need to be allocated by donors to enable this to happen at the earliest possible date.
- A review of the cost-recovery policy should take place that acknowledges the high level of vulnerability of groups such as IDPs and PLHIV. Greater use should be made of exemptions

from payments for treatment and funds made available by donors in order for this to be possible. PLHIV should not have to pay for treatment for OIs.

- While trade-offs between funding priorities clearly present serious dilemmas, given the already high rates of HIV in the Central African Republic and the factors identified in this report that in all likelihood will fuel the epidemic still further, HIV cannot be seen as an 'add-on' to other humanitarian interventions and a response should be mainstreamed into all projects. Indeed, HIV prevention could legitimately be included as a protection issue in its own right, not just as a side-issue to SGBV. At the very least, all appeals should be asked to explain what the impact of the planned work is likely to be on HIV, what action is envisaged that will help reduce HIV transmission, and an effort should be made to develop HIV-linked indicators as well as fix a budget for this part of the intervention. If necessary, extra resources should be made available in order to be able to carry through this undertaking. This must be accompanied by adequate monitoring to show progress against these indicators and levels of funding obtained.
- International donors should take rapid steps to ensure full funding for the key HIV projects in the Consolidated Appeal for CAR for 2008. Strategies need to be developed to target IDPs' needs with respect to HIV prevention, care and treatment. These strategies should allow for the fact that IDPs are mobile and, when the security situation improves, may return to their places of origin in more isolated areas. To facilitate this step, more health professionals need to be trained in prescribing ARVs.
- Strategies to make more PEP kits available on a timely basis at a decentralised level need to be developed. More medical staff should receive the necessary training to deal with suspected cases of SGBV discretely.
- The ex-combatants in Bouar and elsewhere should be quickly integrated into a demobilisation programme that will provide them with a livelihood. At the same time, or in the absence of a more comprehensive programme, they should be given emergency aid (e.g. hygiene kits, including condoms), treatment for STIs, and enabled to have access to the local VCT programme.
- All international troops stationed in CAR should be given mandatory HIV training and encouraged to come forward for VCT. Condoms should be made readily available to them. Peace-keeping budgets should ensure that adequate resources are put aside to this effect.
- More studies need to be commissioned in order to obtain a better understanding of the social dimensions of the HIV epidemic in CAR. KAP studies targeting particular sub-groups within the population would be particularly valuable.

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## Appendix A

Key informants met during the course of the study (Bangui)

Organisation	Name	Function
<b>Ministry of Health (MSPP)</b>	Dr Marie-Madeleine Hoornaert N’Kouet	Directrice Général de la Population et de Lutte contre les infections sexuellement transmissibles, le SIDA et la tuberculose
<b>RECAPEV (Réseau centrafricain de personnes vivant avec le VIH)</b>	Colette Moussa	President
<b>Médecins Sans Frontière Belgium/Spain</b>	Dr Peggy Massamba	Deputy Medical Coordinator
<b>International Rescue Committee</b>	Dr Ruhana-Mirindi Bisimwa	Medical Coordinator
<b>UN System</b>	Toby Lanzer	Resident and Humanitarian Coordinator
<b>UNDP</b>	Dr Abdoulaye Baghou	Management Unit, Global Fund Programme
<b>UNFPA</b>	Dr Ndanga Seraphim Desta Mechecha Dr Malam I. Inoussa Dr Madress Isaac	HIV Programme Officer Chief Technical Advisor Gender Humanitarian Action Assistant Assistant SR-HIV/Humanitarian Action
<b>UNAIDS</b>	Dr Louis Ponzio	Coordinator Central African Republic
<b>OCHA</b>	Jean-Sebastien Munié	Head of Office
<b>UNICEF</b>	Valérie Serres	Programme Officer HIV/AIDS

## Appendix B

Key informants and focus group discussions, Bouar

Name/Group	Function/location
Martine Fatimé Gabrielle Zemmingui	Deputy Head of Bouar Office, WFP Field Monitor, WFP
Roger Keman	Director, Ngaduru Nawa Sida
Focus group with 7 PLHIV women	WFP Food distribution through the Ngaduru Nawa SIDA project at the Lutheran Church, Bouar
Blanche (12-year old PLHIV)	WFP Food distribution through the Ngaduru Nawa SIDA project at the Lutheran Church, Bouar
Paul Nambozuina Barnabe Mayoka	Head of laboratory, VCT Centre Head of IEC, VCT Centre
Col. Jean Pierre Delle-Waya Dr. Gbokassa Daou	Commander-in-chief, Camp Leclerc, Bouar Medical doctor, Camp Leclerc, Bouar
Focus group with 3 women former-combatants	
Focus group with 6 members of an association of ' <i>filles libres</i> ' (sex workers)	
Focus group of 8 IDP women	
Focus group of Peulh IDP women	
Dr Bonezoui Donatien Dr Joaquim Tanguere	Head of the Prefectural Health Division Head doctor at Bouar Hospital
Philippe Nai-Mon	President of Ebe Biro In Sida (local NGO)
Jenny Vaughan	Head of Bouar Office, Mercy Corps