HIV and Emergencies
Haiti Country Case study

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Fiona Samuels and Helen Spraos

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Overseas Development Institute
111 Westminster Bridge Road
London SE1 7JD
UK

Tel: +44 (0)20 7922 0300 Fax: +44 (0)20 7922 0399
www.odi.org.uk

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List of Acronyms

ART	Anti-retroviral Therapy
BSS	Behavioural Surveillance Survey
CAR	Central African Republic
CNDDR	National Commission for Disarmament, Demobilisation and Reintegration
CSWs	Commercial Sex Workers
DPC	Direction de la Protection Civile
EMMUS IV	Enquête Mortalité, Morbidité et Utilisation des Services 2005-2006
FGD	Focus Group Discussion
Gheskio	Groupe Haitien d'Étude du Sarcome de Kaposi et des infections Opportunistes
HRC	Haitian Red Cross
ICRC	International Committee of the Red Cross
IDI	In-depth Interview
IDUs	Injecting Drug Users
INGOs	International Non-Governmental Organisations
IOM	International Organisation for Migration
KAP	Knowledge, Attitudes, Practices
KIs	Key Informants
MDM	Médecins du Monde
MHDR	Mouvement Haïtien pour le Développement Rural
MINUSTAH	United Nations Stabilization Mission in Haiti
MSF	Médecins Sans Frontières
MSM	Men who have Sex with Men
NFIs	Non-food items
OCHA	UN Office for the Coordination of Humanitarian Affairs
STIs	Sexually Transmitted Infections
UCC	Unité de Coordination et de Contrôle du Programme National de Lutte contre les IST et le VIH/SIDA

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Executive Summary

Background and context
Haiti has the highest HIV prevalence rates in Latin America and the Caribbean and the worst AIDS epidemic outside Africa. HIV prevalence, at 2.2 %, is generalised among the population, although slightly more women than men are affected and rates are higher in urban than in rural areas. There are indications that the prevalence rate has been falling over recent years, primarily due to the introduction of a safe blood policy and some – but still insufficient – positive behaviour change among high risk groups. There are believed to have been 103,669 adult PLHIV in Haiti at the end of 2005 out of a total population of 9 million, while according to UNAIDS, there were approximately 16,000 AIDS-related deaths in the same year.

Knowledge about HIV is relatively high and condom use is increasing. The primary modes of transmission of the virus are heterosexual contact. Among the groups considered most at risk of HIV are young people, commercial sex workers (CSWs), men who have sex with men (MSM), migrants (both to urban areas and cross-border), police, prisoners and truck drivers. However, the epidemic is fuelled by chronic poverty, inadequate health services and continuing high levels of stigma and discrimination towards PLHIV. The number of sites where VCT and ART are available has increased significantly over recent years but coverage is still insufficient to enable easy access for people living in isolated rural areas. A new National Strategic Plan has recently been introduced which highlights the need to adopt a multi-sectoral approach in order to tackle the chronic vulnerability that is the key to the fight against HIV/AIDS.

Basic health indicators in the country are extremely poor, reflecting the lack of basic sanitation and the difficulty that many people face in gaining access to quality health services. The state sector is responsible for only 30% of health centres and is unable to regulate and coordinate the other providers adequately. Additionally, health services and trained professionals are concentrated in the major towns and, in all but a handful of cases, attempts to decentralise control to the Unités Communales de Santé (UCS) have failed to get off the ground. As a result, health costs are prohibitively high for poor people, who are often forced to sell assets in order to pay for life-saving treatment.

This situation can be explained by a lengthy history of political instability and neglect of public service provision. GDP has been falling for the past 25 years, leaving a situation where close to three quarters of the population are poor and more than half live in extreme poverty. Although more people are still employed in agriculture than in any other sphere of activity, productivity is extremely low as a result of the lack of basic inputs, environmental degradation and marketing opportunities. In urban areas, particularly the capital, unemployment is high, whilst the remainder of workers unable to find stable jobs are concentrated in the precarious informal sector. Migration has been one way people have found to avoid the worst poverty and for a high proportion of households, income is boosted through transfers from internal or international migrants. Other important coping strategies that ultimately contribute to increased vulnerability include charcoal production, asset depletion and – particularly for women – transactional sex.

Poor people's livelihoods are further eroded as a result of the repeated shocks created by political instability as well as the natural hazards to which the country is exposed. In 2004, serious political unrest came to a climax with the departure from office of former President Aristide, leaving a power and security vacuum that prompted the international community to appoint a UN peacekeeping force known as MINUSTAH. For the following two years, high levels of urban violence resulted in the loss of livelihoods, population displacement, reports of widespread gang rape, as well as threatened the survival of the state. This situation was finally brought under control in early 2007 following the election a new president, Rene Preval, and the combined efforts of the blue helmets and the Haitian police.

Haiti's geographical location, on the path of annual hurricanes, puts the country at a natural risk to violent storms for 6 months of each year. However, these risks have increased over the years as a result of serious environmental degradation, uncontrolled urbanisation and climate change, which together have put increasing numbers of people at risk from flash floods. Several thousand people died in two catastrophic events in 2004 and other areas are regularly affected by localised flooding. This study looked particularly at the impact of Tropical Storm Noel on PLHIV and the various aspects of HIV. 73 people are believed to have died as a result of the storm that passed over the island in late October 2007, and more than 20,000 families have been affected. However, in certain instances, the impact of this incident simply compounded damage that occurred as a result of the earlier Hurricane Dean (August 2007) or bad weather in October 2007 that had serious effects in certain localities in the Western department.

Cultural factors that influence the spread of HIV include multiple sexual partners for both men and women and early sexual initiation. Gender discrimination leaves women dependent on men with little ability to negotiate the terms of their relationship and at times obliges them to consent to transactional sex. Violence against women is widespread. Traditional religious practices can also carry certain risks for HIV transmission but, in contrast with mainstream society, vaudou allows space for open expression of homosexuality, which otherwise remains taboo.

The programmatic response to the emergencies: general and HIV related

Over and above an international military and police presence to help re-establish security, little has been done in terms of a programmatic response to the violence in Haiti. Some humanitarian organisations have been able to provide assistance to affected populations, but many others were unable to operate in the no-go areas. Since these areas have been brought back under state control, other organisations have come in with projects designed to restore confidence and promote peace-building. A disarmament and demobilisation programme has been initiated by the government, while some steps are being taken to address gender-based violence by strengthening the legal framework and improving services to victims.

The response to the flooding has been more systematic and organised. A decentralised structure for disaster management is now in place, although still inexperienced. Local committees were effective at organising the evacuation of people at risk during the recent flooding and at organising emergency assistance. However, most of the shelters were open for only a short period and the aid received was not always sufficient to reach everyone. There is little assurance of longer-term assistance for those who suffered serious losses so that an unknown number of people have been left in a situation of heightened vulnerability to HIV and other serious misfortunes.

In neither context has HIV been adequately addressed. During the flooding, other immediate needs tend to have been prioritised and condoms were seldom available despite an apparent demand. The needs of PLHIV have not generally been taken into consideration either. Nonetheless, key service providers have managed to continue functioning in difficult circumstances and have developed systems for ensuring that access to ARV is not seriously disrupted. MINUSTAH has a small but active HIV/AIDS Unit and some NGOs have included awareness-raising on HIV into their response packages. UNAIDS is starting to explore how the UN system can incorporate HIV into its own emergency operations and created a small fund for such purposes after Tropical Storm Noel.

Vulnerabilities to contracting HIV during the emergencies

Findings from the interviews with people effected by the emergencies shows that sexual promiscuity as well as transactional sex increases during these periods. In the evacuation shelters, out of a combination of boredom, seeking solace from the trauma caused by the flooding and in exchange for favours, people are likely to engage in casual sex. Since condoms are mostly not available in these shelters, people place themselves in heightened risk of contracting HIV. Whilst there was no evidence that sexual and gender based violence has been a problem in the shelters, where it has been occurring is in the locations which faced the conflict and violence,

where women were often raped by gang members. Invariably, it is women who are more at risk of such acts. Generally violence against women in Haiti is widespread and the conflict situation merely exacerbated this.

The study spoke to a group of self-identifying sex workers; they maintained that they always use condoms, whatever the situation. Nevertheless, a key informant suggested that since most of their clients were from outside the area, during the flooded periods the roads were closed so clients were likely to have reduced in number. This may have resulted in sex workers engaging in sex without condoms out of desperation thus increasing their vulnerability to contracting HIV. Additionally, the street-based sex workers, who are less organized and less likely to have access to condoms, are likely to have suffered even more during the flooding.

Vulnerability to contracting HIV also is likely to have increased because of reports of increases in diseases associated with flooding e.g. malaria. Such diseases, along with poor hygiene and sanitation, lower people's immunity and thus also heightens their risk of contracting HIV.

Resilience and coping during emergency situations

As described above, formal sector employment is minimal in Haiti and the majority of people are involved in small-scale petty trading. During the emergencies most people lost much of their property including items that were used for the petty trading and small livestock. As such, when asked what people were doing in terms of livelihoods the response tended to be nothing, that they were begging and that their children were going without food.

A key means of coping by people affected by the emergencies is to move to the shelters and to remain there until the flooding has subsided. There appears to be a reluctance by many people to leave the shelters as there they are given food, blankets and other items; reluctance to leave is also heightened by the fact that the rehabilitation of their homes and livelihoods remains uncertain as the government has unclear strategies of how to deal with such issues. This is not to say that food is sufficient in the shelters, but it is better than having nothing.

Family, friend and neighbour networks are key coping strategies during both flooding and political conflicts. People spoke about going to stay with neighbours, friends and family members during the different kinds of emergencies. Some sent children away to be with relatives or friends in safe places. Staying at people's houses, however, is only a short-term solution as it places increased stress on the receiving household and all those displaced mentioned that either they were asked to leave or felt themselves that they could not stay.

Another means of coping with the emergencies, is to resort to different forms of transactional sex, including selling sex in exchange for cash. The self-identifying sex workers spoken to had all taken up this work as a result of poverty in general and having to support family members 'back home'. Whilst the link is less direct, it can be said that the general situation in Haiti, which is one in which overlapping emergencies have been occurring for decades, has pushed women into engaging in sex work. For the women spoken to in Cite Soleil (a shanty settlement in Port-au-Prince which was the scene of some of the most violent clashes between gangs and later on, the peacekeepers) who do not identify themselves as sex workers (or at least did not to us), being linked to a man is their only means of survival and making a livelihood.

Vulnerabilities of PLHIV during the emergencies

Since PLHIV continue to face considerable amounts of stigma in Haiti, many choose not to disclose their status and as such have not faced any additional vulnerabilities or marginalisation as a result of the emergencies. Of those spoken to who have disclosed their status, they were pushed out of their homes or had financial support from families curtailed. Others have said that the stigma they have faced is worse than the violence and other emergency situations in which they find themselves. Thus whilst there were stories of gangs in the conflict areas, for instance, wanting to

eliminate PLHIV and people in the shelters wanting to throw out PLHIV, none of the PLHIV spoken to had witnessed increases in discrimination or violence as a result of the emergencies.

Supplies of ART and adherence do not seem to be an issue during both conflict/violence related and cyclone/natural disaster kinds of emergencies. Some people spoke about making sure they had them to hand even during the flooding; others said that whilst they were washed away, they went straight away to the hospital and were given fresh supplies; others said that because they had sufficient to last them for a month they had not yet run out of supplies.

The PLHIV woman spoken to in Cite Soleil, most of who had a close relationship with the hospital where we interviewed them, said that they could get condoms if they wanted to and the emergency did not upset the supplies of condoms (though, perhaps access may have been curtailed for a few days during the height of the emergency since people did not move from their houses). Nevertheless, because of stigma associated with being HIV+ most of the women had not disclosed to partners and were not using condoms with them because if they did, they feared that their partners would suspect and beat them or throw them out of the house.

Resilience and coping amongst PLHIV affected by the emergencies

Similar to the above, the main means of coping for PLHIV during emergencies is to move to stay with friends, relatives as well as into the shelters. Another strategy adopted by both HIV+ and others is to send children to other relatives. It can be argued that this occurs perhaps more frequently amongst HIV+ people as their health and ability to provide a livelihood for their children is already affected and is exacerbated further by the emergency.

A crucial means of gaining access to food for PLHIV is by being given food aid. During the period of violence there were some reports that the food was taken away by the armed gangs. Nevertheless, what is more of an issue is the potential stigma that is associated with getting food aid as people often come to suspect that those who are receiving the food aid must be positive. As a result, various strategies are adopted by PLHIV to get round this, including some even refusing food aid and thus jeopardizing their health and survival. The sharing of food with family and friends is a common strategy as it also means that when they have something they will also give to in return. But also one hears accounts of being forced to share.

Whilst no PLHIV themselves reported this directly, there is a sense that it is more difficult for PLHIV to recover after an emergency, be it violence/conflict or flooding. The inability to recover is linked to both loss of assets and other resources but importantly is linked to the stigma associated with being HIV positive.

The effects of the emergencies on service provision – health services

For PLHIV on ARVs, as already mentioned, their supply of ARVs was not affected by the emergencies, both flooding and conflict related. Contingency plans were put in place by the main suppliers of ARVs to ensure that people would have a continued supply of ARVs.

As already mentioned condom availability was extremely limited and mostly non-existent in the evacuation shelters. But the availability of condoms appears to be an issue throughout the country, whether in an emergency or not. Whilst the places providing PMTCT and VCT themselves do not appear to have been closed or affected due to the violence, and availability of PMTCT and VCT sites is increasing throughout Haiti, still many people are not using them.

Issues of blood contamination and unclean equipment do not seem to be a problem in Haiti both in normal situations and during the emergencies: a tightly controlled blood safety programme coordinated by the Haitian Red Cross is in place as well as strict programme on how to treat and dispose of biological waste and needles.

The effects of the emergencies on service provision – other basic services

Whilst people were given food in the shelters, there were also many reports that it was not sufficient and had to be shared around. Clearly, for those who had not gone to the shelters, for which we have little information, they did not receive food and had to rely on others to support them. Lack of food was also a cause for quite a few people on ARVs to stop taking them. This, however, is not directly related to the emergency – unless, clearly, one sees the broader situation of food security in which Haiti finds itself as one of emergency.

Many people report that their children stopped going to school as a result of the emergencies, both violence and flooding. Additionally, even if the schools were not affected by the flooding in many places they were used as evacuation shelters and had to be thoroughly cleaned and disinfected once the evacuees had left.

Drinking water in Haiti is a problem generally and was clearly made worse as a result of the flooding. Additionally as a result of the flooding, in certain communities water and irrigation systems were destroyed, and water became polluted. It would require considerable amounts of time until these systems were put back into working order. It was also pointed out the damage the flooding had caused to infrastructure where in some areas landslides but caused roads to be washed away, as such making some areas impassable.

Summary

- The evidence from this study shows that vulnerabilities to contracting HIV increase in emergencies settings: transactional sex increases, people have limited access to condoms and people's immunities decrease as a result of illness and poor sanitary environment.
- Since most PLHIV do not disclose their status, they are not affected disproportionately by stigma, discrimination or violence; for those who have disclosed, the stigma and rejection they have faced is sometimes worse than being subjected to the flooding and conflicts.
- For those on ART, the emergencies do not seem to have affected their access to ART and their adherence; those providing the ARVs have a range of contingency plans to ensure people continue to take their medications.
- Non-availability of food often leads to people missing ARVs; this situation is common to Haiti in general, whether a heightened emergency or not, but perhaps it can be said to be more acute during emergencies.
- Other HIV-related services do not seem to have suffered during the emergency, but in general whilst there are reports of increase in services related to PMTCT and sites providing ARVs, insufficient people are accessing them.
- A relatively effective system of emergency response is now in place; however, there appears to be little awareness amongst organisations of the need to consider HIV-related vulnerabilities in the emergency response.
- Once the immediate and life-threatening stage of an emergency is over, it is left to other institutions to deal with the rehabilitation and reconstruction phase, many of which do not have the necessary resources to be able to respond adequately.

Recommendations

- Since vulnerability to HIV increases during emergencies, responses need to be tailored accordingly and include awareness-raising on the risks associated with increase transactional sex
- To help mitigate this risk, condoms need to be made more readily available in emergencies, one relatively easy means of making condoms available is to ensure that they are included in the kits that organisations hand out; in addition, they need to be made availability in shelters even during short-term emergencies.

- More generally, the fact that condoms are not provided free in Haiti needs to be taken into consideration when dealing with HIV-related vulnerabilities and risks.
- When people are in shelters, they have little to do, as such organisations could take advantage and carry out awareness-raising activities about HIV, including stigma and discrimination.
- It would be useful if a system were established which would enable PLHIV to come forward to ensure that any additional needs emerging as a result of the emergency can be addressed; The Direction de la Protection Civil is well placed to establish such a system.
- Finally, more research is needed in a number of areas including: what happens to those who do not go into the shelters; better estimates of displaced and other mobile populations; studies on specific groups who are vulnerable to HIV (MSM, street-based sex workers); and why uptake of services including PMTCT and post-rape care and counselling remains so low.

1. Introduction

ODI, in partnership with WFP and supported by UNAIDS, is carrying out a study on HIV and emergencies. The study 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 someway 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 Haiti country case study. Haiti was selected for a number of reasons: it has faced decades of overlapping emergencies, i.e. recurring natural disasters (cyclones and flooding) and political instability leading to periods of severe violence and conflict. Furthermore, HIV in Haiti has a long history with the first cases being reported in the 1980s and it has the highest HIV prevalence rate outside Africa. Finally, it was important to have a case study in the Americas in order to explore the themes of interest to this study in this particular geographical and cultural context.

Following this section, an account of the methodology used for the study will be given along with the challenges faced by the researchers. Section 3 describes the country context in terms of the history and nature of the emergencies - both natural disaster and conflict - the epidemiology of HIV in Haiti, as well as the livelihood and cultural contexts. These are important framing issues needed to understand the impacts of the emergencies on vulnerabilities to contracting HIV and similarly, how PLHIV cope and adapt to the various emergency settings. This is followed by section 4 which describes the programmatic responses to the emergencies, whilst section 5 explores the impact of the emergencies on PLHIV and on vulnerability to contracting HIV. The final section draws out some conclusions and recommendations.

2. Methodology of assessment

The assessment was carried out by a team of 2 consultants, an international one and a Haiti based consultant. Prior to the fieldtrip, discussions took place regarding whom to visit as well as the most appropriate sites for the study. Given the nature of Haiti with its multiple and overlapping emergencies, i.e. regular natural disasters and ongoing, sometimes latent, political conflict and violence, it was important to include these different perspectives in the study. About 2 weeks before the fieldtrip was scheduled to begin, Tropical Storm Noel[1] hit various areas of southern Haiti including the South East and West, the latter being the department where the capital, Port Au Prince) is situated. It was decided, therefore, to include a visit to Jacmel in the South East, which had been hit by Noel, since it was expected that the impacts, coping, etc, would be fresh and easily visible. Other areas that had been affected by previous episodes of flooding were also visited. Thus, St Marc (a town which has also experienced a short period of acute violent conflict) in the Artibonite, and Cabaret and Montrouis in the Western Department, were included in the study.

What also became clear through visits to these sites and discussions with people there, was that not only were these natural disasters regular and cyclical occurrences (especially during the peak of the Hurricane Season between August – October), but that the frequency and impact of heavy rainfall is increasing. This can be attributed to the consequences of serious deforestation, uncontrolled urbanisation resulting in intensive construction in precarious locations, people's declining asset base as well as climate change. As a result, there are frequently more than one episode of flooding in any one season and the effects and responses to them blend into one. This was the case in the South East where, not long before Tropical Storm Noel, the area was hit by Hurricane Dean, so that similar groups were affected and the responses that have been initiated are hard to distinguish from one another.

However, despite the serious consequences of these unfavourable weather systems, the scale of the flooding experienced in Haiti in 2007 is not as serious as other events that have occurred in the past and were liable to affect the country in the future. In such a scenario, the country's coping capacity would be more severely tested than has been the case during the course of the current study.

In addition to visiting sites which had suffered natural disasters, field visits were also made to areas which have been badly affected by armed violence over the last 5 years, particularly in the capital Port-au-Prince. These have also sometimes been affected by natural disasters. Cite Soleil, a shanty settlement with a population of approximately 300,000 which has been the scene of some of the worst fighting between the gangs and the UN peacekeepers (MINUSTAH). The area has only recently been brought under state control, though there are still fears that kidnapping and other forms of violence may recur. In addition to this visit, discussions were held with people from a range of settlements around Port-au-Prince which have faced and continue to face political violence.

The assessment consisted of a combination of: interviews with key informants (KIs) from a range of organisations including the state, INGOs, NGOs and UN organisations, these included service providers and policy makers; in-depth interviews (IDIs) with PLHIV: focus group discussions (FGDs) with people affected; reviews of secondary and grey materials collected during the fieldwork; and observations and visits to houses destroyed by the floods and to one of the shelters to which people were evacuated. A total of 23 KIs were carried out, this included some discussions in which 2 or more people were present – 19 in Port-au-Prince, 2 in Saint Marc and 2 in Jacmel; a total of 10 IDIs were held with PLHIV – 4 affected by the flooding (3 in Jacmel, 1 in Cabaret) and 7 IDIs with women in Cite Soleil; a total of 5 FGDS were held – one with PLHIV

[1] A tropical storm is less intensive than a hurricane but can nonetheless bring heavy rainfall. Indeed, such rainfall has proven potentially equally or more damaging in Haiti than the high winds associated with the more powerful hurricanes.

affected by the violence around Port-au-Prince, one with PLHIV affected by the flooding around Saint Marc, one with people affected by the flooding in Cabaret/Montrouis, 1 with sex workers in Saint Marc and 1 spontaneous and unplanned discussion with a group of women who were still in an evacuation shelter post Tropical Storm Noel (see Annex 1 for list of people interviewed).

A number of challenges were faced by the team. Firstly, there was very little secondary information and material, both quantitative and qualitative, available on a number of aspects of interest to the study. There was, for instance, very little data on the issue of displacement both as a result of natural disasters and political violence. Whilst some figures were obtained on, for instance, the recent displacement caused by Tropical Storm Noel, these were just the numbers of people who had presented themselves to the evacuation centres. Those who had gone to stay with relatives or friends were most probably more numerous but no one had any idea of the precise numbers. Similarly, the credibility of the figures, even when they were available, was raised by many KIs. On displacement caused by political violence, again many people spoke about leaving the 'hot' areas, going to stay with relatives within Port-au-Prince or in rural areas and then returning after some months or years. Nevertheless, estimates of these numbers of displaced are unavailable.

Whilst there are some studies (both qualitative and quantitative) on the behaviour of certain groups, e.g. youth and sex workers, these are very small-scale and localised studies, thus making it difficult to extrapolate to a national context. Similarly, little data was available on groups particularly vulnerable to contracting HIV: whilst by many accounts men-who-have-sex-with-men (MSM) are numerous in Haiti, little was known about them and accessing them was problematic due to high levels of stigma attached to homosexuality[2]. No information was obtained on injecting drug users (IDUs), but according to many informants, IDUs are extremely few in Haiti (see e.g. discussion with Director of HRC)

Due to some logistical problems regarding transport, the trip north had to be shortened and some of the intended site visits had to be postponed.

3. Country context

3.1 Epidemiology

Haiti has the highest HIV prevalence rates in Latin America and the Caribbean and has the worst AIDS epidemic outside Africa. Haiti's epidemic is a generalized one. A population-based survey in 2005 estimated that adult prevalence rate (15-49) was 2.2% (Cayemittes et al., 2006). This figure represents a slight improvement on previous estimates[3] in which the adult prevalence rate was estimated in 2003 to be between 2.5 and 11.9% (WHO, 2005) but remains the highest in the Caribbean. Among pregnant women attending antenatal clinics, HIV prevalence declined from 5.9% in 1996 to 3.1% in 2004 (Gaillard et al., 2006)[4]. The declining trend is largely related to decreasing infection levels in Port-au-Prince and other cities, where HIV prevalence among 15–44-year-old women fell from 5.5% to 3% between 2000 and 2005. Additionally, lower prevalence rates are primarily attributed to the introduction of the safe blood programme, rapid mortality, and the impact of various interventions that have succeeded in bringing about behavioural change among

[2] The team was told about a study which explored MSM behaviour but they were unable to get hold of the study report.
[3] Ministère de la Santé Publique et de la Population (2007), *Haiti: Enquete Mortalité, Morbidité et Utilisation des Services 2005-2006.* In the past, estimates had been based on sentinel studies amongst pregnant women rather than on a population-based survey, a fact which may explain some of the recent fall observed in estimated rates of infection over recent years.
[4] In conversation with a key informant in Haiti they pointed out that prevalence rates amongst pregnant women had in fact increased to 4.1%.

high risk groups, such as youth and sex workers (Gaillard et al, 2006)[5]. Behavioural surveys have shown a 20% drop in the mean number of sexual partners between 1994 and 2000, while condom use increased, especially during sex with non-regular partners (Cayemittes et al., 2006; Hallet et al.,2006; Gaillard et al., 2006, UNAIDS 2007 Epi-update)

Within this overall pattern, there is a degree of regional variation, with the highest rate of prevalence to be found in the department of Nippes (3%) and the lowest in the South East (1.4%). The rate in the metropolitan area of Port-au-Prince, at 2%, is slightly under the national average, and is the same as that for rural areas[6]. Possible reasons for a lower prevalence rate in Port-au-Prince could be because HIV related services are better there than elsewhere in the country; similarly, since awareness raising programmes are more numerous in Port-au-Prince than in other parts of the country and started earlier, it is possible that their effects are starting to be felt in terms of reducing prevalence rates.

Recent statistics also appear to show a clearly discernible trend towards a feminization of the illness, with women now having a slightly higher prevalence than men (a ratio of 1:1.15)[7]. Whereas all age groups are affected, the rate among men is highest among those aged 40-44 (4.4%); while for women, those aged 30-34 are most affected (4.1%).[8] In terms of income, it is those in the middle range that have the highest prevalence (EMMUS IV)[9].

Among the groups considered most at risk of HIV are young people, commercial sex workers (CSWs), migrants (both to urban areas and cross-border), MSM, police, prisoners and truck drivers. Whilst Haiti-wide statistics on these particularly vulnerable groups are lacking, some smaller studies have been tracking key indicators and some also have been collecting biological samples: the preliminary results of a survey in 2004 to determine drug use and HIV infection rates among former soldiers entering into police service found that 30% of the soldiers tested were HIV positive (WHO, 2005).

In a BSS of 335 CSWs in 2003, an HIV prevalence rate of 10.1% was found (Soto and Gerard, 2005); currently, the repeat study[10] is showing that 67.9% of CSWs used condoms with their last client (interview with Director of Palih). A BSS amongst vulnerable groups – CSWs, drivers of public vehicles, migrants, MSM, street children and men in uniform was done by FHI in 2006 (FHI, 2006). Preliminary results show that, compared to 2003, several indicators for most groups have improved, e.g. in 2003 50.9% of CSWs had gone for HIV testing, this increased to 76.6% in 2006, amongst MSM it had increased from 9.4% to 50.5% and knowledge about HIV amongst all groups is high. One exception to the overall improvement is condom use, where indicators are inconsistent with, for instance, only 1.1% of drivers of public vehicles reporting condom use at last sexual encounter with non-regular partners compared to 72.8% for MSM and 93.5% for CSWs.

A recent KAP survey has been conducted among male UN military and police personnel belonging to MINUSTAH. This showed that troops receive regular training and have a relatively good knowledge of HIV but with significant variations between the different contingents. Only 6.5% of respondents said that they had sex during the course of their mission (although the authors of the study recognised that the methodology used may encourage under-reporting), but 30% had done so during their time-off[11]. Condom use was found to be high but inconsistent (greater than 87% while on mission and over 50% while on leave), with participants generally knowing where to obtain them. The report carries the important recommendation that pre-deployment HIV training

[5] Others point to the limitations of the sentinel studies that focused on pregnant women largely in urban areas, by definition a relatively high risk group.
[6] There is, however, a slightly higher rate of prevalence in urban areas other than greater Port-au-Prince (EMMUS IV)
[7] 20 years ago the ratio was 1 woman to 5.6 men (MSPP, 2007)
[8] EMMUS IV
[9] In other words, the third and fourth income quintiles, although men from the second quintile are also disproportionately affected
[10] A re-survey has been done in 2007 but results are not yet public.
[11] There is no indication where this time-off takes place, and whether it is in Haiti or elsewhere.

should be more systematically provided to a uniform standard and encourages the use of peer educators as a means of promoting appropriate knowledge and behaviour.

Currently no data exists on prisoners and HIV infection rates. The prison population is estimated at around 6000. For the past 2 years WHO, in collaboration with ICRC, has been trying to initiate an HIV prevention and condom distribution programme with prisoners; the aim is also to carry out a KAP survey. So far these efforts have stalled due to the unwillingness of some prison authorities. Nevertheless, accounts exist of tattoos and penis implants taking place in the prisons using unsterilized equipment. Currently TB treatment is given and when prisoners are released they are followed-up; prison authorities do not separate out TB patients. WHO are reluctant to do HIV testing because if prisoners test positive the availability of ART may not be ensured and stigma may also set in – though they know of one prisoner who was on ARVs before being imprisoned and is taken to Gheskio every month. Additionally, if unsterilized equipment is being used and no condoms are available it makes better sense to at least start with a prevention programme.

On the basis of recent data, there are believed to have been 103,669 adult PLHIV in Haiti at the end of 2005[12] out of a total population of 9 million, while according to UNAIDS, there were approximately 16,000 AIDS-related deaths in the same year[13]. This represents a reduction from previous figures where an estimated 280 000 adults and children were living with HIV/AIDS at the end of 2003, and an estimated 24 000 adults and children died from AIDS during 2003 (WHO, 2005). EMMUS IV estimates the number of orphans and vulnerable children to be 24% of the total population, while estimates of the number of PLHIV aged less than 15 are given as approximately 17,000 (MSPP, 2007).

The primary means of HIV transmission is through sexual contact[14], followed by vertical (mother-to-child) transmission. Transmission from injecting drug use or blood transfusions is said to be negligible since the introduction of a blood safety programme by the Haitian Red Cross in 1986. Blood is now almost entirely sourced from unpaid volunteers and is regularly screened (interview with Dr Pape, Gheskio and HRC).

Although knowledge about the disease is relatively high, behaviour change has been harder to achieve. Condom use is increasing but remains limited. Only 29% of young women and 43% of young men used condoms during their last high-risk sexual contact[15]. On the basis of interviews conducted for this study, condom access can sometimes be a problem, particularly in rural areas or for groups (including CSWs) that cannot always afford to purchase even the subsidised brand (Kapot Pantè).

The HIV epidemic in Haiti is fuelled by endemic poverty, inadequate health and social services that have been further weakened by chronic political instability, high internal migration rates and a high prevalence of sexually transmitted infections (STIs). Recurrent gender-based violence, multiple sexual partners for both men and women, and women's inability to negotiate condom use with men are all factors which are contributing to HIV transmission. Stigma and discrimination against PLHIV is extremely high, a factor which deters many people from revealing their status, even to their close family, as was confirmed by most of the FGD participants consulted in the course of this study. It is worth noting that MSM are a potentially important group but are said to be hard to reach given the taboo surrounding homosexuality.

[12] Ibid.
[13] Gouvernement de la République d'Haïti, Plan Stratégique National Multisectoriel 2008-2012
[14] Heterosexual transmission is responsible for 90% of new cases (Hemptsone H. et al (2007)
[15] EMMUS IV

3.2 Health environment prior to the emergency

Health indicators in Haiti are extremely poor. Only one third of children of less than one year are fully vaccinated, infant mortality stands at 57 per 1000 live births, while maternal mortality has continued to rise over recent years to reach 630 per 100,000 live births (EMMUS IV). Rates of TB and STIs, both strongly associated with HIV, are also particularly high (Hempstope et al., 2004). Moreover, standards of nutrition are low with only limited access to sanitation and clean water: 24% of children of less than 5 are chronically malnourished, while 46% of women suffer from anaemia. More than a third of households have no toilet (50% in rural areas), and only 55% use an improved source of drinking water (EMMUS IV).

Only 30% of health facilities are state-run, primarily in urban areas, and these suffer from a lack of trained staff, equipment, funds and basic drugs. Given the extremely fragile and in many cases non-existent government health system, private institutions have stepped in as the main providers but their fees are nonetheless prohibitive for the poorest and the quality of service questionable (World Bank, 2006). Coordination of a multiplicity of institutions throughout the country poses a serious challenge.

In addition, most health services and trained professionals are concentrated in the major towns and, in all but a handful of cases, attempts to decentralise control to the Unités Communales de Santé (UCS) have failed to get off the ground. Access to health care therefore remains a significant obstacle for most of the population and families are forced to sell assets, such as land or livestock in order to meet the costs of health care, thereby further impoverishing themselves. Similarly, the most frequently cited reason for not seeking treatment is cost, followed by distance (69% of the poorest households live more than one hour away from the nearest health centre) (EMMUS IV). Instead, 70% of people prefer to use traditional health practitioners - including traditional birth attendants (*matwòn*) - as a first port of call (UNDP, 2004) even though, in the case of HIV/AIDS, traditional healers are ill-equipped to provide appropriate treatment.

In recent years, access to VCT, PMTCT and ARVs has expanded greatly, thanks to the support of PEPFAR and the Global Fund. There were 161 VCT sites in 2006, doubling from 88 in 2005; sites offering PMTCT have increased from 2 in 2002 to 99 in 2006, though only 35% of women found to be HIV positive during their pregnancy receive the necessary drugs to prevent transmission to their offspring (Gouvernement de la République d'Haïti, 2007). The number of sites providing ART has similarly increased from 2 in 2002 to 36 in 2006 and the number of patients on ART is estimated at 10,000 as of 2006, half of whom are getting ART through Gheskio, the leading HIV treatment centre in the country (interview with Director of Gheskio)[16]. The organisations providing ART are numerous and include NGOs, FBOs, state hospitals, etc. Thanks to PEPFAR and the Global Fund, ART is now provided free to all patients. Nevertheless, people still frequently incur significant costs having to travel for several days in order to receive their medicines at the centres providing ART. Whilst increasing in number, these centres are still concentrated in urban areas and the remote areas of Haiti remain largely underserved in terms of ART provision. Furthermore, because of stigma, people often choose to travel outside their areas of residence so as not to raise suspicions of their status. This problem of access is a major one that needs to be taken into consideration at times of emergency.

The recently adopted National Strategic Plan 2008-2012 to overcome HIV has the merit of introducing a more multi-sectoral approach than has previously been the case, and of seeking to involve a wider range of stakeholders in order to help reduce the impact of the epidemic. This is

[16] Gheskio was set up in 1982 and has gained an international reputation for the research it has carried out in the field of HIV. It offers a variety of services to the Haitian public including VCT, PMTCT, PEP and counseling for rape victims, as well as running a paediatric AIDS facility and playing a major role in providing training to health professionals. It is currently responsible for supervising 46 sites throughout the country.

potentially a significant factor in taking meaningful steps to overcome vulnerability and to ensure an adequate response in emergency situations.

3.3 Livelihood contexts of the country/area and people

In parallel with the political instability, the country's economy has declined steadily over the past 20 years. Per capita GDP fell by 2.8% annually from 1990 to 2004 (UNDP, 2005), leading to a situation where 71% of the population live below the poverty line of $2 per day, with 55% of people living in extreme poverty (less than $1 per day) (MPCE, 2004). Inequality is also high: the Gini coefficient is estimated to be 0.65 (Egset and Sletten, 2005), higher than that of Brazil. International aid during this period has fluctuated wildly, with the imposition of an embargo during the 1991-94 coup and a further interruption of donor support to the government as a result of concerns about poor governance in the early years of this decade. There is a recognition, however, that such withdrawal of external assistance has contributed to undermining institutional capacities, and hence the effectiveness of international aid (World Bank, 2006).

Although there is a strong trend towards urbanisation, Haiti's population is still 60% rural and the most extreme poverty tends to be concentrated in rural areas[17]. The North East and North Western departments have the highest incidence of extreme poverty (84% and 72% respectively), but whereas the West has the lowest incidence, the fact that it is the most populous means that it nonetheless has the highest number of extremely poor people in that department (23% of the total, Egset and Sletten, 2005). Female-headed households, those with large numbers of dependents and non-migrants also tend to have lower incomes. In terms of access to basic services (health, education, water and sanitation), on the other hand, the Central department suffers the most seriously from inadequate provision (MPCE 2004).

The principal source of livelihoods in rural areas is from agricultural production (crops and livestock) and trade, with additional income coming from daily labour and crafts production. Agricultural productivity, however, is extremely low and falling as a result of the very small areas of land available to each family, environmental degradation, competition from cheap food imports, as well as the lack of state support, infrastructure – notably roads and irrigation - and access to essential inputs such as technology and credit. As a result, Haiti is only able to provide 54% of its own food needs, with 29% of the rest coming from commercial imports and 8% in the form of food aid, leaving a structural food deficit of 9%. As a result, at least 56% of the population is thought to be under-nourished (CNSA, 2002).

Formal sector jobs are concentrated in urban areas, and the capital in particular. Regular employment is to be found in the public sector and in the small private sector (assembly plant industry, banking, commerce) but unemployment – particularly for the young – is high in towns at 23% overall, and twice as high for the 20-30 age group (World Bank, 2006). The remainder of workers are concentrated in the informal sector, which is characterised by low levels of productivity and a high level of uncertainty.

In this context of declining incomes, it becomes hard to distinguish the impact of disasters from that of gradual impoverishment due to broader considerations. Given this situation of ever-increasing vulnerability, shocks to poor people resulting from various emergencies simply serve to compound an already strong negative trend. In such circumstances, migration – whether to cities or across borders - has become one of the most common coping strategies adopted by Haitian people. 51% of residents in the capital were born in other parts of the country, and several million are believed to be living abroad (primarily in North America, the Dominican Republic and other parts of the Caribbean). According to the World Bank (2006), Haiti is the world's most remittance-dependent

[17] 82% of the rural population lives below the poverty line of $2 per day (MPCE, 2004). It is worth noting, however, that 24% of the extremely poor nonetheless are to be found in urban areas, with conditions in some areas being equated by WFP to near-famine throughout the year (CNSA, 2002)

country, with over $1 billion sent home by migrants every year[18]. Indeed, 40% of Haitian households receive some form of transfer, although it is important to note that poor families tend not to benefit from these additional external sources of income.

Other frequently-used survival strategies are reducing food intake and/or removing children from school, sale of productive assets, production of charcoal, and – particularly for women – transactional sex. Participants interviewed during the course of this study had adopted most of these strategies in response to the situations they had experienced, whether as a result of armed violence or flooding.

3.4 History of emergency

3.4.1 Political instability and armed violence

For much of its history, Haiti has been subject to widespread political instability and bad governance that has tended to overlook the needs of the poor majority. Since the overthrow of the 30-year Duvalier dictatorship in 1986, the country has suffered from particularly serious turbulence that has prevented the country from making a full transition to democracy and has contributed to weakening the already fragile state. A coup d'état in 1991 against the recently elected President, Jean Bertrand Aristide, lasted for 3 years, and was marked by serious repression of sectors believed to support the ousted President. During this period, an international embargo was imposed on the country, and standards of living fell drastically. Aristide returned to office again in 2000, only to be forced out of office in 2004 by a protest movement which culminated in an armed insurgency that took control of parts of the country. A transition government, led by Prime Minister Gérald Latortue, took charge of the country with the backing of an international peacekeeping presence. New elections were finally held in February 2006 that resulted in an overwhelming victory for a new president, René Preval.

While the combatants who had fought for Aristide's departure were gradually brought under control and demobilized, supporters of the former president began a movement to bring about his return, known as Operation Bagdad. This uprising, which was concentrated in the urban slums of Port-au-Prince, became increasingly violent, with clashes occurring between the armed groups and the UN forces. This situation went hand-in-hand with growing levels of crime that affected much of the population and turned parts of the capital into no-go areas controlled by armed gangs loyal to various political factions, bringing the country's weak political institutions to the brink of collapse. During 2004-06 the Commission Episcopale Justice et Paix recorded 2222 violent deaths in Port-au-Prince, which occurred alongside widespread shooting, robbery and extortion. Kidnappings in particular reached unprecedented levels during 2005-06. The United States State Department reports 760 kidnappings in 2005 and a further 554 in 2006[19].

The people most severely affected by this insecurity were the population of the poor areas of Port-au-Prince through the loss of income and the closure of essential services. Houses and businesses were destroyed, forcing significant numbers of people to leave their homes. Schools and health centres ceased to function for lengthy periods. Women have been particularly seriously affected as a result of their role as the main breadwinner and carer for their families as well as victims of the violence. Many of them lost their small trading activities that were the main source of their livelihood, often bringing them into debt and straining their ability to provide for their children's basic needs and that of their families. A practice of collective rape in areas under the control of armed groups has been widely reported as a means of exerting control over the local population (Loutis, 2006, and Larrain and Fernández, 2007).

[18] The World Bank estimates that $1,184m was sent back to Haiti in 2007, an amount equivalent to several times that which the country has been receiving in international aid in recent years (http://siteresources.worldbank.org/INTPROSPECTS/Resources/334934-1199807908806/Haiti.pdf consulted on 21/1/08)
[19] http://www.state.gov/g/drl/rls/hrrpt/2006/78895.htm consulted on 14/1/08

Since Preval assumed office in May 2006, armed violence and insecurity have gradually been brought under control. The new government, using the combined efforts of the international forces and the Haitian National Police, have successfully restored control over the whole of the country.

3.4.2 Flooding

Because of its geography, Haiti is subject to a range of natural threats, including hurricanes, flooding, drought and earthquakes. While these have historically taken a serious toll on the country[20], such events have tended to become more frequent and intense over recent years as a result of serious environmental degradation caused by widespread deforestation and ensuing soil erosion. At the same time, the extreme vulnerability of the local population has been growing as a result of increasing poverty and uncontrolled urbanisation. As a result, people in Haiti - and invariably the poorest are those who suffer the most - have found themselves exposed to repeated shocks that have gradually contributed to the erosion of their assets. Drought, flooding, political upheaval and other events have interacted to further undermine their already precarious livelihoods, often prompting them to deplete their asset base still further, thereby creating a context of chronic/permanent and increasing vulnerability.

The hurricane season runs from 1 June to 30 November each year, affecting the southern coastal areas in particular. Even the less powerful tropical storms represent a serious menace given the impact heavy rainfall can have on the fragile environment. Moreover, serious localised flooding regularly occurs outside the hurricane season as a result of ordinary but intense rains. Deaths are regularly recorded in Port-au-Prince and elsewhere as a result of flash floods that cause walls and buildings to collapse in shanty areas and lead to loss of livestock and harvests elsewhere.

The heavy rainfall brought by Tropical Storm Noel, which passed over Haiti on 29-30 October 2007, came in the wake of serious localised flooding in the course of the previous month (affecting Cabaret and Orangers in the West), as well as the serious damage caused a few months earlier by Hurricane Dean (18-19 August 2007). Dean affected the southern coastal region in particular. The final assessment issued by OCHA and the DPC shows a total of 14 dead and 2 missing, 8905 families affected, 2183 houses destroyed and a further 6376 damaged. More than 9500 people were taken into temporary shelters, and the FAO estimates that $6 million of damage was caused to agricultural production, putting 10-12,000 families at risk of increased food insecurity[21].

The damage caused by Tropical storm Noel was most serious in the Western, South, South East and Artibonite departments. Official figures prepared by OCHA/DPC show that 73 people died, with a further 17 missing, 21,726 families were affected, 3852 houses were destroyed and close to 18,000 damaged. No figures have been obtained for economic losses sustained or of the impact on agriculture, but people interviewed indicated the seriousness of such losses (including damage to roads, drinking water and irrigation systems as well as food production, livestock) and the fact that food prices are likely to rise as a result of the destruction of local crops.

3.5 Cultural context prior to the emergency

Both men and women tend to have multiple sexual partners and to engage in serial monogamy or polygamous sexual relations, with marriage often being the exception rather than the norm (EMMUS IV). Young people become sexually active early (15% of young women and 43% of young men before the age of 15, with the average age of first sexual relations at 16.6 for men and

[20] Hurricane Flora in 1963 caused 5000 deaths and $180 million in damage, while Hurricane Gordon was responsible for 1122 deaths in 1994 (Mathieu et al., 2002). Two events in 2004 - serious flooding in Fond Verettes and Mapou in September of that year, followed by Hurricane Jeanne in September that flooded the town of Gonaives – were responsible for upward of 3000 deaths.

[21] Organisation des Nations Unies pour l'Alimentation et l'Agriculture, Unité de Coordination des Urgences Agricoles, Ouragan Dean, Haiti – Aout 2007/Bilan consolidés des dégats agricoles. This estimate does not include loss of livestock, damage to fruit trees or damage to irrigation systems.

18.1 for women) (EMMUS IV, 2007)), while on average, women are 5.5 years younger than their partner. It has been suggested that poverty is likely to force women into an early sexual debut and multiple partners (Hempstone et al., 2004) and that their economic dependency on men means that they are unlikely to be able to negotiate the terms on which the relationship takes place.

Women are often said to seek alliances with men as a means of ensuring survival for themselves and their families, reflecting the unequal gender relations that operate within society. This same reality is likely to encourage casual sex work, as well as occasional transactional sex in return for certain favours such as a job (Spraos, 2007). This phenomenon can be expected to increase in line with increasing vulnerability or at times of crisis, and it is a factor that should be taken into consideration during an emergency response where women may seek to barter sexual favours in return for access to food or other forms of material aid.

Despite being considered the *poto mitan* (central pillar) of society and bearing much of the responsibility for both their families' welfare and for the circulation of goods, women face serious inequality and discriminatory attitudes. They have little control over resources or influence over public affairs (women are seldom present in key decision-making posts). 44% of households are headed by women (53% in urban areas) (EMMUS IV, 2007), leading many women to complain that the abandon of their children by the father is a form of violence.

Violence against women is a serious problem in Haiti, as has been demonstrated through a number of recent studies (e.g. Larrain and Fernández, 2007). Rates of sexual violence are high, with credible reports of collective rape taking place during periods of acute political instability, notably during the 1991-94 coup d'état and in areas controlled by gangs after the overthrow of Aristide in 2004 (Loutis, 2006)[22].

Homosexuality remains a serious taboo that prevents men from revealing their sexual orientation or programmes and projects carrying out effective targeting of MSM, despite the fact that they are a high-risk group. However, there is also a degree of tolerance towards homosexuality that is explained by the fact that, according to traditional vodou beliefs, male and female spirits may seek to possess both men and women, thereby justifying a-typical behaviour.

In other respects, the link between vodou and HIV is an area that has been given relatively little attention and deserves to be better understood. There are certain practices that may favour transmission, for instance, including sexual contact and ritual scarring (the practice known as *prann gad*). Moreover, given the regular recourse to traditional healers, many of whom combine this role with a spiritual one, such practitioners can be encouraged to become a useful ally in the fight against AIDS (e.g. through referring people who show AIDS symptoms to the formal system). A few examples of this way of working exist. APROSIFA, an organisation working in the Carrefour Feuilles district of Port-au-Prince, for instance, has worked with local religious leaders including *ougans* (vodou priests) to raise their awareness about HIV, to encourage them to promote the use of condoms and to refer people showing symptoms of AIDS to their clinics. However, such cases remain isolated examples rather than a systematic attempt to incorporate traditional healers in a more strategic way.

Despite the fact that 32% of women and 41% of men are considered to have a full knowledge of HIV (EMMUS IV), stigma and discrimination against PLHIV remains extremely high (see section 5.2).

[22] Larain and Fernández (2007) indicate that 33% of the cases recorded by institutions supporting victims of sexual violence in 2004-05 were victims of collective rape.

4. Programmatic responses

4.1 What was the emergency response?

4.1.1 Armed violence

The most significant response of the international community to the violence and political instability that surrounded the departure of former President Jean Bertrand Aristide from office in 2004 was the creation of an international peacekeeping force, MINUSTAH (UN Stabilization Mission in Haiti), whose mandate was renewed for a further 12 months in October 2007. The Mission is currently composed of over 7000 UN troops (including contingents from Brazil, Argentina, Jordan, the United States and Sri Lanka), with a further 2000 police and approximately 500 civilian employees[23]. The mandate of the Mission includes facilitating a humanitarian response, and interventions such as emergency medical evacuation or routine consultations, urgent infrastructural repairs and distribution of water and foodstuffs have been carried out at various times to assist affected populations. MINUSTAH has also been involved with a task force aimed at developing a strategy for improving conditions in the country's shanty town areas (UN Security Council, 2007).

Other than this, very little has been done in terms of a programmatic response to the violence. Many institutions were unable to operate in the no-go areas during the peak of the violence. However, some humanitarian organisations, such as ICRC, MSF and MDM, have been able to provide medical and other forms of assistance, taking advantage of their neutrality and credibility with the local population. Gheskio, which is located in an area that has been subject to both violence and flooding, has remained open almost uninterruptedly and its staff have never been threatened (interview with Director of Gheskio).

Other organizations, such as the International Organisation for Migration (IOM), took on a rehabilitation role immediately after the no-go areas were brought under state control. They have carried out large-scale quick impact programmes designed to contribute to the rehabilitation of some of the most seriously affected areas. The Haitian government has created a National Commission for Disarmament, Demobilisation and Reintegration (CNDDR) and is making efforts to increase numbers of police through an intensive recruitment and training process. In addition, a small number of INGOs, among them Concern Worldwide, have introduced peace-building programmes aimed at tackling the problems that have fed some of the worst urban violence.

While not necessarily as a direct result of the armed conflict, an increasingly effective response to gender-based violence is being implemented. The legal framework was strengthened in 2005 to make rape a criminal offence (instead of an offence against public decency as had previously been the case), while a protocol has now been established to ensure that women are given appropriate care following sexual assault. There are a growing number of centres offering PEP to prevent HIV infection after rape, although these are currently concentrated in Port-au-Prince.

4.1.2. Floods

Haiti has begun to make good progress towards the creation of a nationwide disaster management system. A National Risk and Disaster Management Plan was adopted in 2001. Under the leadership of the Civil Protection Directorate of the Interior Ministry (DPC), a network of national, departmental, communal and ultimately local committees are being set up. The Committees include representatives of the relevant ministries and the Haitian Red Cross as well as locally elected officials, and links exist with donors and international agencies. OCHA, the UN Office for the Coordination of Humanitarian Affairs, is responsible for coordinating the international response. An extensive network of Red Cross volunteers is also called upon at times of emergency, as well as groups such as the Scouts, who can be mobilised to assist with evacuation efforts.

[23] http://www.un.org/Depts/dpko/missions/minustah.

The response to Tropical Storm Noel was coordinated by the DPC in conjunction with OCHA, although the response mechanisms that were brought into action are relatively new and inexperienced. Nonetheless, at the departmental level, the committees are active and were undoubtedly responsible for limiting the loss of life. The Committee in the South East, for instance, was responsible for evacuating people at risk during both Dean and Noel, as well as for organising shelters (13 for the second storm) and for distributing emergency assistance (food, NFIs, medical attention, etc). Where it was not possible to distribute food directly, local officials were enabled to purchase essential items through a system of credit. According to certain key informants, however, one of the problems experienced generally has been the fairly poor quality of damage assessments and the slow pace of information flow due to the difficulty of reaching some of the people affected and the inexperience of many of the people responsible for carrying them out. Moreover, there appears to be a lack of clarity over responsibility for longer-term interventions oriented towards rehabilitation and recovery.

Nationally, 18,756 people[24] were taken into shelters for the duration of the emergency following Noel, during which time they received food and most essential services. An unknown number were taken in by relatives and friends. Rather than using specially designed constructions, public buildings, such as schools and town halls, were used as makeshift shelters. During the most acute phase of the emergency, various institutions such as WFP, UNICEF and various NGOs were providing hot meals, high energy biscuits or dry food rations to those in shelters, as well as medical assistance, distributing water and non-food items of various kinds (hygiene and cooking kits, mattresses, blankets, clothes, etc). In the case of Grande Saline in the Artibonite, which is regularly flooded each year, WFP used boats to reach people in need of food aid when road access was cut off.

On the basis of the testimonies provided by focus group participants, people in shelters did not all manage to benefit from the aid distributed and there was not always enough to go around. In some cases, for instance, male relatives remained close to the home to keep watch over the family's possessions. Because they were not registered at the shelter, they did not receive any rations and the food had to be shared among more people than was intended. At the shelter in Bon Repos visited (a disused hospital), although some bottles had previously been distributed, there was no drinking water available and food distribution had been stopped in order to encourage people to return home. Some people had received cooking equipment and mattresses but there were not enough for everyone to benefit. There were no toilet facilities and the water available for washing was very dirty. On the other hand, there was adequate space and, perhaps because of its proximity to Port-au-Prince, several NGOs have provided a limited amount of assistance. MDM Canada had made several visits to offer medical consultations, during which they also carried out some health education sessions, while Save the Children organised an activity for children. A committee had been formed by people in the shelter but its effectiveness and authority were unclear.

In most cases, the shelters were closed after about a week - some of them after only a few days, since they had to return to their intended use - but a few were still open at the end at the time of the field work for this report (19/11/2007). The expectation is that most people will resume their regular lives and that those who have been made homeless will find accommodation with close friends and family pending any longer-term assistance that can be mobilised. It is clear that informal solidarity mechanisms do ensure that many people are taken in for a short while. However, at least in the West, people have been reluctant to move on and they are not always able to find more than a temporary home. In Cabaret, focus group participants claimed that shots were fired in the air to force people to leave the football pitch where they been camping and that the water supply was cut off. Some of them have had to move on several times since then, having found no permanent place to stay.

[24] UNDP/DPC presentation to the Humanitarian Forum on 15 November 2007. More than 9,500 people were evacuated to temporary shelters during the passage of Hurricane Dean according to the final report issued by the same institution.

It is not yet clear to what extent the response to the medium-term recovery and rehabilitation phases will enable the people most affected to rebuild their livelihoods, as the exact needs had not been identified at the time of the study nor adequate funds received. Moreover, these later stages are the responsibility of the Planning Ministry (MPCE) rather than the DPC itself, potentially leading to problems of coordination and continuity. In the opinion of Mme Alta Jean-Baptiste, Director of the DPC, it is unlikely that enough resources will be found to cover the true extent of the losses. As a result, there is likely to be serious hardship for certain people who have lost homes and their chief means of survival, leaving them in a state of extreme vulnerability.

4.2 How was HIV addressed in the emergency response?

4.2.1 Violence

HIV has barely figured in any of the response to the armed violence. The main priority for national and international authorities has been to re-establish state control over the no-go areas and little attention has consequently been given to additional concerns in anything more than a sporadic way. Nonetheless, although some health centres were obliged to close, several key service-providers continued to function for all but a few days of extreme tension. Gheskio, despite being located close to violent areas, claims to have been functioning for all but one day and has never been attacked, despite refusing to pay protection money to gangs in the area. It has nevertheless had to develop contingency plans to help avoid a number of potentially serious problems. A system has been developed whereby stocks of ARVs have been placed at certain sites that are more accessible to PLHIV on treatment than the main centre, and a few extra days' supply of drugs is given to clients in case services are interrupted.

MINUSTAH's structure includes a small HIV/AIDS Unit whose brief is primarily internal, leaving external interventions to other institutions. Most of its activities are directed towards prevention and education for the peacekeeping personnel, including VCT, although it also works with the Haitian National Police and has carried out one-off interventions targeting youth and other vulnerable groups among the wider Haitian population. It carried out approximately 3000 HIV tests were carried out last year, a number which is said to be steadily increasing. According to the head of the Unit, the mission is effective in covering the personnel in Port-au-Prince but less so for those stationed in other parts of the country (the results of a recent KAP study undertaken amongst UN military personnel are described in Section 3.1 above).

It is important to note that there have been a number of cases where reported sexual misconduct by Mission personnel has led to their expulsion from the country. In November 2007, 111 Sri Lankan soldiers were sent home in response to cases of alleged abuse, while at least one other case was brought to public attention by a human rights network at the same time. However, the lack of accountability to the Haitian government means that there is no certainty that the cases will be adequately prosecuted in their home countries nor that victims will be given adequate support. Clearly, in such circumstances, there is a risk of HIV transmission both to the Haitian and the home population that cannot be adequately addressed without much greater transparency and appropriate strategies to offer adequate protection in situations of this kind.

4.2.2 Floods

On the admission of most of those met during the course of the study, HIV has only marginally been taken into consideration in the response to the recent flooding. This is perhaps not surprising given the relatively recent creation of the national response mechanisms, which have tended to focus on addressing the most obvious immediate needs (food, water, medical care and shelter, in particular). The National Risk and Disaster Management Plan, adopted in 2001, does not refer to HIV (DPC, 2001), nor does the new Multi-sectoral Strategic Plan for the Fight Against AIDS (Gouvernement de la République d'Haiti, 2007) explicitly address emergency situations. Nonetheless, the latter does seek to bring together representatives from various ministries and institutions in attempting to involve them in the response to the epidemic. In the opinion of the

UCC[25]) representative interviewed, this structure will enable a clearer definition of responsibilities for HIV in emergency situations, create appropriate communications channels as well as lead to the elaboration of operating guidelines for interventions[26].

As a result of the new National Plan, each body represented within the system is expected to prepare its own plan that will respond to the priorities established. UNAIDS, as part of its mission to coordinate the multilateral and bilateral partners supporting the fight against AIDS in Haiti, has started to convene a joint team to look at the role of the various UN agencies in meeting this challenge. Emergency response has been identified as an area that should be addressed through this mechanism, for instance by including HIV considerations in any appeal that is presented to donors for support towards the disaster response. This is an encouraging initiative but has not got beyond the early planning stages at present and is not yet operational.

Condom distribution is reported to have taken place on occasions to people in shelters in Gonaïves in 2004, but it seems to have taken place only in very specific cases during the recent flooding because of the short period during which most shelters were kept open. An exception appears to be Cabaret where, according to a Red Cross representative, condoms were distributed and used. This highlights the fact that there is a demand for condoms even over the very short-term, as was clearly expressed by some of the women met at the Bon Repos shelter. Despite this, many of the hygiene kits distributed do not seem to have contained condoms, which would be a relatively low-cost means of preventing HIV transmission at a time of particular vulnerability.

In general, the needs of PLHIV have not been taken into consideration during the recent response either. However, in one incident in the South East, the Civil Protection Committee was forced to take a strong stance when a group of people in a shelter in Bainet, opened after Hurricane Dean, protested at the presence of a number of PLHIV. The Committee responded by carrying out awareness-raising sessions aimed at reducing stigma surrounding HIV and made it clear that anyone protesting would be excluded from the shelter.

Otherwise, a few isolated examples did occur that demonstrate how the challenges of HIV can be integrated into an emergency response. For instance:

- UNAIDS has made available a small budget of $10,000 which has been set aside in order to help address the needs of PLHIV affected by the recent flooding[27]. These funds are to be administered by UNFPA in coordination with the Platform of PLHIV Associations, which has supplied details about a number of its members who have been seriously affected by the floods.
- Certain NGOs have carried out small-scale interventions that address one or other aspect of HIV. One example is that of KORAL, a small NGO working on livelihoods in the South, which has integrated awareness-raising on HIV into its response to Tropical Storm Noel, using Christian Aid and ACT International funding[28].

Despite the relatively limited nature of actions taken to address the challenges of HIV during the response to the flooding, it is worth pointing out that most of the officials met recognize the need to integrate a more thorough response in the future.

[25] State body until recently responsible for the coordination of the national response to HIV/AIDS.
[26] Although it is likely to be an unintentional omission, the Interior Ministry (MITC) to which the body responsible for coordinating the national disaster response, the Direction de la Protection Civile, belongs, is not listed as one of the bodies to be included in the CNLS (the National Commission for the Fight Against AIDS). This omission should be corrected.
[27] However, it appears that the procedure is somewhat long and no funds had yet been disbursed at the end of November 2007.
[28] Internal working document, 30 November 2007.

5. The effects of the emergency

5.1 On vulnerable groups

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

One of the main features of the flooding is the evacuation of people to shelters. As described above, these shelters are usually existing buildings which are turned into refuges for a certain period; buildings used include schools, old hospitals and even private houses. Stories were mixed regarding how people were arranged in the shelters: some people said there were separate areas for men and women, others said that families were put together and others still said that people were anywhere and everywhere. Similarly, some said that the women and children stayed at the shelters, whilst the husband (or perhaps an older child) returned to watch their home for fear of theft; this is clearly dependent on the distance between the shelters and the homes, and also the extent of the damage and destruction. In Jacmel when interviewing a woman, it emerged that whilst she stayed in the shelter with her younger son, her 18 year old son remained by the house, looking after the few remaining possession they had. One can perhaps assume, therefore, a mix of different kinds of ways of coping with the emergency according to a number of criteria, including the distance to the shelters, the severity of the flooding, the duration of the flooding and length of stay in the shelters.

On the basis of the interviews and focus groups conducted for this study, there is no evidence that sexual and gender-based violence has been a major problem in the shelters. This is in keeping with a finding during the previous response to the flooding in Gonaives in 2004 when UNFPA promoted monitoring of gender-based violence. However, there is a general consensus that consensual and transactional sex is likely to occur given the extreme vulnerability of many people and the shortage of goods that are distributed. Increase in promiscuity is, therefore, likely to result because of a number of factors including the following: since there is a lot of mixing, people may end up close to others that they are unfamiliar with and may be curious and sexual encounters therefore may follow; with the trauma people faced as a result of the flooding, they may want to seek comfort in others, so may engage in sexual relationships that perhaps they would not have done otherwise; whilst waiting to be re-settled, there are limited activities that people engage in, thus out of boredom they may decide to enter into sexual relationships; with limited opportunities to earn a livelihood during this period, it is also likely that people may engage in some form of transactional sex, though this was not raised by any respondents.

The following is a translation from one of the committee members in Jacmel: “There are too many people in the rooms, promiscuity is rampant, people want to stay nearby the people they know, so even if it is overcrowded they want to stay with their own “tribe”. They had tried to separate people but they didn’t want”. He later went on to say, that “whilst there is a room for women and for men, with children staying with women, at the schools it’s difficult, can’t stop certain things happening”.

During a focus group discussion with people affected by flooding in Cabaret, when asked whether they knew of any sexual abuse in the shelters, one person said ‘it must happen’ and continued to say that the ‘security’ can easily take advantage of the women in return for favours given that there’s not enough to go around. One person during the discussion even accused the mayor of being among those responsible for committing rape in the shelters.

Clearly, these increases in promiscuity and sexual relationships lead to an increase risk of HIV transmission. In discussion with a group of women in the Bon Repos shelter, most of them had heard about HIV but did not know many details: some said that when someone “gets diarrhoea, gets spots, also on the tongue” it means they have HIV; another woman talked about getting HIV from mixing of blood, making love and from beauty parlours; another said that you only get it from someone who is HIV+, and as she only goes with her husband she is OK. A few mentioned the link between the importance of using condoms and being able to protect themselves, though others said they did not like condoms, one was on the pill, one had had an injection and another said she was not having sex. What was clear, however, was that condoms were not available at the shelter:

according to one woman, “We don’t get them; we need them”. This was also confirmed by the HRC person in charge of the Bon Repos shelter who said that condoms had not been made available there, although she admitted they might be useful, continuing by saying that they did distribute some in Cabaret and she found used ones on the ground, implying that if they were available people would have used them. A key informant from MDM also reported that during her visit to another shelter (in Tabarre 33) people, both men and women, were asking for condoms to be distributed.

Another complaint raised by people who had been affected by the flooding and who had been in shelters was that post the flooding periods, mosquitoes and malaria became widespread, including in areas in which it had been almost eradicated. When someone contracts malaria, their immunity is lower and hence it could be suggested that their vulnerability to contracting HIV may also be increased during these situations. Additionally, due often to less food, limited drinking water supplies and unclean sanitary environment (both latrines and dirty water), people become more susceptible to getting diseases and infections which also leads to reduced immunity and therefore heightened risk of contracting HIV.

As mentioned in section 2.0, little is known about people who are displaced and who do not go to shelters. All informants spoke about such people going to stay with neighbours and family members. It is also likely, therefore, that in these situations, when people are away from home, causal and un-protected sex happens.

During the focus group discussion with sex workers in St Marc, they insisted that they always use condoms with their clients and this had never changed even during the flooding period (St Marc had also witnessed some serious violence and political upheaval in early 2004 but none of the sex workers spoken to had been there during that period). These were sex workers who were based in a brothel and who were linked to an NGO where they received free condoms and other incentives. It seems they could only be part of this organization if they underwent regular HIV tests[29]. We did not speak to street-based sex workers who, by their very nature are less organized and have less access to condoms. A key informant in St Marc suggested that since many clients of sex workers are from outside St Marc, during the flooded periods the roads were closed so clients were likely to have reduced in number. This may have resulted, according to the key informant, in sex workers engaging in more sex without condoms out of desperation.

Whilst domestic violence and violence against women in particular is reported to be relatively high in Haiti (see section 3.5), during the conflict and period of political unrest, violence and in particular sexual violence, including rape and gang rape increased. According to a set of IDIs carried out with women in Cite Soleil, they all spoke about fearing sexual abuse and rape; some mentioned knowing of women who had been raped during the conflict.

According to this 23 year old woman, who lives alone and is pregnant, sexual violence has never happened to her, but she knows of people. “That’s what happens here, you just have to accept, they will organize themselves, they will take out a knife, so you can’t do anything about it. It can be several men (10), they only do it once, won’t start a relationship. Victims will come to the hospital but will come later, as it is shameful to be raped” She continued saying that: “It is not like that now, because there are the ‘leaders’, the ‘whites’ around”; here she is referring to the fact that the UN peacekeepers are a common sight in areas such as Cite Soleil.

5.1.2 Resilience – how have these vulnerable groups coped with the emergency

As was described above, a key means of coping during the floods was to move to the shelters set up by the state and to rely on family and neighbour networks. In the shelters, food and water was being provided. Accounts of the food vary with some people saying there was not enough to go around, and people had to share and keep what they were given to eat later on in the day; others

[29] It was unclear what would happen to them if they were found to have sero-converted.

say that the food was sufficient and the kinds of foods they were given were better than what they would eat at home (Director of MHDR). During the visit to Bon Repos, drinking water seemed to have been a problem, since the supply provided by the HRC had run out and people had to buy it[30]. The HRC representative, who accompanied us on the visit, took note of this and arranged that day for water to be brought to the shelter.

There was a sense from some members of organisations supporting the emergency response, that people evacuated to the re-settlement centres used these regular evacuations as means of getting new mattresses, blankets, kitchen utensils and food. Their reluctance to move away from these areas which are vulnerable to flooding could partly be seen as supporting such an argument. Clearly, however, there are numerous other reasons why people may not want to re-settle not least if this is where they own small plots of land and where they have family and other connections. During the visit to the Bon Repos shelter it became apparent that the people where reluctant to leave the centres partly because they had nothing to return to, since their livelihoods had been washed away, and they were waiting for help to rebuild their livelihoods, but also partly because they would continue to received some form of support if they remained. This was also the case in other shelters, as reported by key informants.

Family, friend and neighbour networks are key coping strategies during both flooding and political conflicts. People spoke about going to stay with neighbours, friends and family members during the different kinds of emergencies. One man, who had been in St Marc during the violence, had to go on the run and was moving from place to place, staying with different friends. Some sent children away to be with relatives or friends in safe places – though interestingly all except one out of the 10 participants of the FGD with flood victims in Cabaret managed to stay together as a family group. In Cite Soleil one women reports: “During the height of the shooting my children went to stay with a friend in Tabarre for 1 month. During this time, I was frightened, my heart was beating fast, I couldn’t eat, I was also worried for my children”. Others turned to friends for assistance: rather than move to a shelter with his mother and younger brother, an 18 year-old boy in Jacmel camped outside his house, which had been destroyed during the flooding, sharing food with his friends. Staying at people’s houses, however, is only a short-term solution as it places increased stress on the receiving household and all those displaced mentioned that either they were asked to leave or felt themselves that they could not stay.

As described in section 3.3, informal sector employment is minimal in Haiti and the majority of people are involved in small-scale petty trading. During the emergencies most people lost much of their property including items that were used for petty trading and small livestock. As such, when asked what people were doing in terms of livelihoods the response tended to be nothing, that they were begging and that their children were going without food.

In Haiti in general, there is a widespread reliance on external handouts from, amongst others, churches and NGOs. This reliance is heightened during emergency situations. People also borrow and informal savings schemes, known as Sol or Sabotay, are quite widespread[31]. During the discussion in the Bon Repose centre, most of the women mentioned being part of one. Some micro-credit schemes have also been set up, but often when one is too poor and vulnerable, they do not work as was explained by the director of MHDR because their capital is used to cope with pressing daily needs instead of renewing the stock

Another means of coping with the emergencies, is to resort to different forms of transactional sex, including selling sex in exchange for cash. The self-identifying sex workers spoken to had all taken up this work as a result of poverty in general and having to support family members ‘back home’. Whilst the link is less direct, it can be said that the general situation in Haiti, which is one in which overlapping emergencies have been occurring for decades, has pushed women into engaging in

[30] It is important to point out that drinking water in Haiti is generally a problem, and is merely made worse by the flooding.
[31] Daily or monthly contributions are pooled and paid out to each member in turn.

sex work[32]. For the women spoken to in Cite Soleil, who do not identify themselves as sex workers (or at least did not to us), being linked to a man is their only means of survival and making a livelihood (see also section 3.4). The nurse in charge of the PMTCT programme at the hospital in Cite Soleil said the following: "People (women) will sleep with anyone because they need food and money and because there's no money to send children to school. The only strategy that women have or think of is to go and find a man. Each time they come back to the hospital they are pregnant from another man. It makes work that we do here difficult". She continued to say that she sees women who are beaten up, who come into the hospital with black eyes, but at the same time they cannot leave their husbands as this is their own means of survival. Whilst these issues may be exacerbated in areas such as Cite Soleil given its turbulent history, this is also an issue for Haiti as a whole were domestic violence is extremely prevalent (see section 3.4).

5.2 On PLHIV

5.2.1 Vulnerability - How has the emergency affected existing vulnerabilities?

Since PLHIV continue to face considerable amounts of stigma in Haiti, many choose not to disclose their status and as such have not faced any additional vulnerabilities or marginalisation as a result of the emergencies. Thus the PMTCT coordinator in the hospital in Cite Soleil reports of stories where the woman is HIV+ but is frightened that if her husband finds out he'll leave her, "She has 3 children so what can she do? She thinks that he's suspecting now… One woman came in with a black eye, she was beaten by her husband because she asked to use a condom and he refused. But at the same time, women don't want the men to leave because they rely on them, this is how the virus spreads".

Of those spoken to who have disclosed their status, they were pushed out of their homes or had financial support from families curtailed. One man who has disclosed his status and who is from Portail Leogane, an area of Port-au-Prince that has seen considerable amounts of armed violence, maintains that people's attitudes towards him are far more damaging than the shooting that he has experienced. According to another HIV+ man: "Any person in Carrefour (where he was from) was subjected to violence, but violence against PLHIV is because of stigma not because of the violent situation". Similarly, a focus group with PLHIV in Port-au-Prince said that its not so much that aggression has increased towards PLHIV as a direct consequence of violence, it is more the fact that everyone's standard of living has been squeezed still further that means that people are more likely to demand a share of their food aid.

A key informant from MDM who had been working in the hospital in Cite Soleil for a number of years reported various stories and events that she had experienced regarding discrimination and violence towards PLHIV. At one time there was a rumour that gangs in Cite Soleil wanted to eliminate all PLHIV in the area as a means of preventing the illness from spreading. She went on to say that: "People left their homes (during the violent period in CS) because of a combination of stigma and violence, but it is difficult to separate out the two". She reported a story told to her by an HIV+ woman that as she had been threatened she was forced to leave her house; others lost children because they could continue with PMTCT after moving. One PLHIV had one positive and one negative child: "The mother was coming to get milk for them at the hospital disguised so people would not recognize her, she had a skin problem, her child was very sick, so people were suspecting. The same when, when she starting taking ARVs became well again so people said that she was just bewitched."

During discussions in Jacmel, it emerged that whilst in the most recent flooding there were no stories of stigma or discrimination because it seems that the PLHIV who had been affected had not disclosed their status, during the earlier flooding (cyclone Dean) the issue had been raised. The

[32] There is some limited evidence to indicate that sex work may increase during times of emergency. Two out of 5 sex workers participating in the focus group discussion for this case study had started this profession at the time of the political crisis in 2004, which had serious economic ramifications for many poor families.

health agents who were following people on ART pointed out to those in charge that there were some PLHIV in the shelters and that they may need specific attention, also so that they would not be stigmatized. This followed an event when people in the shelter found out that there were PLHIV there wanted to them to leave, throw their stuff away as they were fearing they could become infected. They were counselled by those in charge and were told that if they did not accept the PLHIV they themselves would be thrown out of the shelter; it seems that calm returned after this (see also section 4.2.2).

Supplies of ART and adherence do not seem to be an issue during both conflict/violence related and cyclone/natural disaster kinds of emergencies. Some people spoke about making sure they had them to hand even during the flooding; others said that whilst they were washed away, they went straight away to the hospital and were given fresh supplies; others said that because they had sufficient to last them for a month they had not yet run out of supplies. Some areas had been cut off during the recent flooding and the only means of access was by boat. In these situations, it was unclear whether people had run out of ARVs. The key informants spoken to, however, said that they thought they would still have sufficient drugs. An 'accompagnateur' working for FEBs in St Marc also pointed out that as part of his job he would go to the flooded areas and ensure that people were taking the drugs and had enough of them. During the violence in Cite Soleil, people still continued to take their ARVs, according to this one woman: "There are times when people/vehicles can't come into this area, but people will always take their meds, it's their life".

It appears, therefore, that the importance of adherence has been ingrained in most of the people on ART, as they were all taking them or going to long lengths to make sure they had them. The fact that supply of ARVs does not appear to be a problem is also triangulated by information received from some of the ARV suppliers, who state that their supply was not interrupted during the emergency periods (see also section 5.3).

Another issue, however, is whether all those who need ARVs are currently receiving them, despite the fact that sites providing ART have increased in the last few years (see section 3.2).Many people spoken to during the study reported going for periods without taking their drugs because, according to them, they do not have the food necessary with which to take the ARVs. Interestingly, the research team did not find any worsening of this situation during the periods of flooding. In some respects, it could almost be argued that people who have been re-settled in centres as a result of flooding may have easier access to food than people who have to fend for themselves during 'normal' times in Haiti.

For the PLHIV woman spoken to in Cite Soleil, since most of them had a close relationship with the hospital and we interviewed them there, they said that they could get condoms if they wanted to and the emergency did not upset the supplies of condoms (though, perhaps access may have been curtailed for a few days during the height of the emergency since people did not move from their houses). One did say that there was not enough and that more were needed. Another said that whilst she could get them she does not need them anymore as she's not interested in having a partner, is sick, can't afford to look after the children (4) that she already has and does not want any more. Nevertheless, what was clear from these women, because of stigma associated with being HIV+ most had not disclosed to their husbands and boyfriends and were not using condoms with them because if they did, they feared that their partners would suspect and beat them or throw them out of the house. Another woman said that whilst she would like a partner she cannot "..if I tell I'm sick they won't want to stay, they will also get sick because won't want to use condoms, so I have to accept to live without a man".

5.2.2 Resilience - How have PLHIV coped?

Similar to the above, the main means of coping for PLHIV is to move to stay with friends, relatives as well as in to the shelters. In Jacmel the Director of MHDR heard that (officially) 30 people had been affected and displaced by the floods; 11 PLHIV came to the MHDR half-way house with their children. The half-way house is essentially used by PLHIV who are coming from outside Jacmel

who either need to go for their regular visit to the hospital (including to stock up on ARVs) or for those who need to start taking ARVs and who may need support in the initial stages. In additional to medical support and accommodation, they are provided with food and psychosocial, nutrition and hygiene counselling. The length of time people stay depends on their individual need. The house sleeps up to 15 PLHIV. During the flooding the director let the 11 and their children stay for 1 night and then found them places to stay with their peers.

During the violence in Cite Soleil and other areas in Port-au-Prince, people moved out going to stay with relatives and friends both in other urban areas as a well as rural areas. Some moved for a few months, others a few years. One woman living with HIV said that when they left Cite Soleil as a result of the violence moving to another area within Port-au-Prince, she was being supported by her mother and her mother was able to continue her business despite moving.

Another strategy adopted by both HIV+ and others is to send children to other relatives. It can be argued that this occurs perhaps more frequently amongst HIV+ people as their health and ability to provide a livelihood for their children is already affected and is exacerbated further by the emergency. Thus an HIV+ woman in Cite Soleil explains how whilst her older and youngest children (11 and 2 years old) are with her, the other 2 are being looked after by mother in Petit Goave. She lives with aunt and younger brother who support her: her brother is a tire repair man but not working now and her aunt sells food. Whilst no one knows her HIV status, others in household want her to leave, saying she a drain on their resources, but she has nowhere else to go so has to put up with it. She used to be a street seller, selling oranges, but since 2004 stopped because of her health.

Whilst the research team probed for the extent to which formal HBC was happening and if so, how it was affected, the concept of HBC seemed to be relatively new in Haiti and people were just beginning to talk about some form of community-based caring. Informal family solidarity nonetheless plays a similar role in some cases. This is encouraged by the involvement of family members in PLHIV support groups organised by NGOs such as POZ, where those involved can then learn about HIV and how to help their relatives live more comfortably. In some of the cases encountered - for instance a woman PLHIV who lost her house in the floods in Cabaret - relatives have taken family-members in despite knowing their status. Yet in other cases, the shelter offered is of temporary duration and the displaced families were uncertain of where they would go in future. This raises the prospect that more families will be broken up, with any HBC that was being offered put at risk.

A crucial means of gaining access to food for PLHIV is by being given food aid. During the period of violence there were some reports that the food was taken away by the armed gangs. According to this woman in Port-au-Prince: ‘I don’t know if it’s because life has become so hard now – hunger is very widespread - that people become *chimè* (gangsters). Because when people are hungry, when they see you with a sack on your head they’re ready to jump on you to take it off you and to beat you up. But you don’t want to get beaten up so you have to share what you have”.

Nevertheless, what is more of an issue is the potential stigma that is associated with getting food aid as people often come to suspect that those who are receiving the food aid must be positive. As a result, various strategies are adopted by PLHIV to get round this. One positive woman tells people that she buys the food (she has a job as a Health Agent at the hospital); another positive woman says that when she is asked how come she has access to food she says: “.. you have to say that you need a card to get food and the cards are now finished”. She continues to say that previously the medical cards for PLHIV were a different colour so people suspected, now the colour has changed and the practice is now also to give food to those with children so people do not suspect. She also added that whilst the food is supposed to be just for her, she shares it with her family and with 3 neighbours, saying that “I have to give them, if not they will hate me”. Sometimes, when the food comes late they have nothing to eat.

The sharing of food with family and friends is a common strategy as it also means that when they have something they will also give in return. A woman on ARVs from Port-au-Prince says other peers who are also on ARVs sometimes share food amongst themselves: “I’m on ARVs and when I tell the doctors my problem they’ll give me a little bit of food that can last a day. Sometimes I’ve got some friends who are also sick and they share with me the rations they have”. But also one hears accounts of being forced to share: one woman from Port-au-Prince explains that once the neighbours found out she was HIV+ she had to start sharing her food so that they would not push her out of the area.

Sometimes, for the sake of survival, some PLHIV refuse the food aid despite it jeopardizing their health and even survival: the PMTCT coordinator tells of a story of a woman who is HIV+ who used to get food aid, but does not any more. According to the nurse, she used not to need it, but because the income of the gangs has fallen (her husband was a gang leader during the violence in Cite Soleil), she does these days, but “..she doesn’t want to take food aid because her husband might suspect and start beating her up”. Similarly, as part of PMTCT they recommend women to use exclusively powder milk for the baby and for those who do, their babies are usually negative. For this woman, however, her husband wanted her to breastfeed the baby for 6 months, and she did so otherwise he would have suspected. They do not yet know whether the baby has sero-converted, but given the situation it is likely.

Whilst no PLHIV themselves reported this directly, there is a sense that it is more difficult for PLHIV to recover after an emergency, be it violence/conflict or flooding. The inability to recover is linked to both loss of assets, sickness and other resources but importantly can be linked to the stigma associated with being HIV positive. According to the MDM key informant: “When the violence stopped, because PLHIV people were often threatened as well, it was more difficult for them to return to their homes”.

Similarly, according to the Director of MHDR: “The needs of PLHIV are like others but higher, so it more difficult for them to recover”. He pointed out that food in the shelters was not sufficient and that hygiene was not good. He also said that if their houses are mended the owner would then charge them higher rents so they preferred that their houses were not fixed.

5.3 On service provision

5.3.1 Health services

The main hospital in Port-au-Prince providing ARVs is Gheskio. Gheskio is located on the edge of an area which has faced and continues to face gang violence. Despite this, the Director said that the gangs have respected the hospital and had not touched it; he had been offered protection by various gangs but had refused. As such there were only a few days perhaps that they had to close during the most violent times of the conflict, otherwise they continued to be open and provide services; their own staff have never been threatened. They are prepared and have contingency plans: they have a pool of cars which provide transport for their staff. They have ARV collection sites spread throughout so people can go and collect at different sites if necessary. If there is a period of crisis rather than give 1 months supply to patients they give 2 months. Additionally, all people on ARVs have the phone number of someone in their area who will bring them medicines if they are facing difficulties in coming to the hospital/the ARV collection points.

Gheskio was also affected by the recent flooding; but once again this did not affect the services and whilst perhaps numbers of patients reduced because of difficulty of them accessing the hospital, the hospital remained open.

The story of Gheskio is mirrored by the hospital in Cite Soleil which also remained open and protected during the height of the violence in this area. Similarly, there were only a few days when it was closed, though as in Gheskio, sometimes people were unable to visit it because of the

shooting. According to the Director of HRC, during the violence in Cite Soleil people who were hurt or wounded were brought out of the area, being transported in tap taps (or local buses).

One woman from Cite Soleil, who works as an 'agent de sante' at the hospital, reported that even during the shooting she was coming to work every day because she lives nearby. She confirmed that the hospital was always open, though said that some services were not functioning. One aspect of her work which was disrupted was that she was unable to go out to sensitize people for 1 week during the worse time as the area as blocked; she also sometimes had to stay at the hospital during most ferocious times.

As was mentioned above, stocks of ARVs do not seem to have been affected by the floods nor the violence. People have always been able to get them. The study did not, however, visit any sites in the interiour that were supposed to be providing ARVs and the key informant from WHO did say that during a recent visit to some sites she found that ARVs were not available. This was not mentioned by anyone else and even if this were true, these were sites which had not been affected by the flooding/cyclones and even if they had been affected by the violence/conflict this had since ceased.

As was mentioned in section 5.1, condom availability was extremely limited and mostly non-existent in the evacuation shelters. But the availability of condoms appears to be an issue throughout the country, whether in an emergency or not. Despite the Director of Gheskio saying that when the price of condoms came down (through a social marketing campaign run by PSI), condom usage increased and can partly be attributed to the fact that the HIV prevalence rate in Haiti has not reached levels similar to those in Africa, the study did not find widespread evidence of widespread use of condoms. Whilst knowledge about the importance of condoms is widespread, access to them is sometimes problematic mostly because the cost for the majority is still felt to be high. During carnival and other festivals condoms are handed out free, this does not appear to be the case during other occasions. Similarly, whilst people in evacuation shelters are given kitchen kits with pots, blankets, toilet paper, none contain condoms. This would be a relatively easy item to include in the kits.

Whilst the places providing PMTCT themselves do not appear to have been closed or affected due the violence, and as was mentioned in section 3.2, availability of PMTCT sites is increasing throughout Haiti, still many women are not using them. Speaking with the PMTCT coordinator in Cite Soleil, she mentioned that despite women coming to test and some starting ARVs, some are afraid to go complete the PMTCT process since they fear violence from their partners and thus risk their babies contracting HIV.

Since 1986 the Haitian Red Cross has been in charge of blood supplies throughout the country which are rigorously scanned to ensure that they are free of any disease. According to many key informants, including the Director of Gheskio, this has been a very successful undertaking and can also help explain the fact that the HIV prevalence rate in Haiti has remained relatively low. This blood safety programme has continued and even during the violence/conflict they have always maintained safe blood supplies; they always had electricity so they were always able to ensure that the blood was tested. The Director of the HRC also said that they have a very strict programme on how to treat and dispose of biological waste and needles, supported by JSI. In short it appears that the possible contamination of blood does not seem to be an issue in Haiti and had not become one even during the recent emergencies[33].

[33] Though the demand for blood seems to have been low. The target is 5 days supply, which seems to me little for coping with a major emergency.

5.3.2 Other basic services, education, sanitation, nutrition

Whilst supply of ARVs is not a problem, see above, a few people mentioned that they had not been taking their ARVs due to lack of food. One women in Cite Soleil, for instance, said that for the last week she has been taking only the morning dose with food, and missing the evening one because has no food. This same sentiment was echo by a number of other PLHIV saying that some days they have to miss drugs because they have not eaten. This, however, is not directly related to the emergency – unless, clearly, one sees the broader situation in which Haiti finds itself as one of emergency.

Whilst people were given food in the shelters, there were also many reports that it was not sufficient and had to be shared around. Clearly, for those who had not gone to the shelters, for which we have little information, they did not receive food and had to rely on others to support them.

Many people report that their children stopped going to school as a result of the emergencies, both violence and flooding. During violence in Cite Soleil, when there was shooting people could not go out of their homes and schools were closed for 2/3 months. During the flooding again children could no longer go to school for a combination of reasons including: the schools were closed, people lost the money needed to pay for school fees; the children were sick as a result of the flooding; and/or they had lost their school clothes. Additionally, even if the schools were not affected by the flooding in many places they were used as evacuation shelters; in some areas this coincided with a school holiday, but in other areas the children could not continue with normal schooling. After the schools had been used as shelters, they had to be thoroughly cleaned and disinfected since once the evacuees had left they were in a considerable state of disarray, since the sanitary facilities were insufficient for such an influx of people.

Drinking water in Haiti is a problem generally and was clearly made worse as a result of the flooding. In the shelter in Bon Repos people were obtaining water for washing from an uncovered well and the HRC was providing drinking water but it was not sufficient (see also section 5.1). Additionally, as pointed out by the committee in Jacmel, as a result of the flooding, in certain communities water and irrigation systems destroyed, and water became polluted. It would require considerable amounts of time until these systems were put back into working order.

The committee members also pointed out that in some areas roads were destroyed, there were landslides and parts of roads were washed away, thus making some areas impassable. As a result, they predicted that prices of basic products would increase, making people increasingly vulnerable.

6. Key Findings and recommendations

6.1 Key Findings

- The evidence from this study shows that vulnerabilities to contracting HIV increase in emergencies settings: transactional sex increases and people have limited access to condoms. As a result of disease, illness and poor sanitary environment, people's immunities also decrease which in turn increases their susceptibility to contracting HIV.
- Since most PLHIV do not disclose their status, they are not affected disproportionately by stigma, discrimination or violence. Nevertheless, stigma is a widespread phenomenon in Haiti and for those whose status is publicly known, the stigma and rejection they have faced is sometimes worse than being subjected to the flooding and conflicts that were occurring.
- Interestingly, for those on ART, the emergencies do not seem to have affected their access to ART and their adherence in general. Those providing the ARVs support this by having a range of contingency plans to ensure people continue to take their medications.
- What does seem to affect the taking of ARVs for many is the availability of food, and many people report missing doses because they do not have sufficient food. This situation is common to Haiti in general, whether a heightened emergency or not, but perhaps it can be said to be more acute during emergencies. This is also supported by the fact the PLHIV are often the ones receiving food support and during emergency times there were reports of the food being taken off them.
- Other HIV-related services do not seem to have suffered during the emergency, but in general whilst there are reports of increase in services related to PMTCT and sites providing ARVs, the issue is still that insufficient people are accessing them, be it in an emergency or not.
- A relatively effective system of emergency response is now in place: evacuation at the time of Hurricane Dean and Tropical Storm Noel was effective and no doubt helped saved lives and short-term shelters and immediate needs have been provided for tens of thousands of people.
- Despite the above, there appears to be little awareness amongst organisations of the need to consider HIV-related vulnerabilities in the emergency response, thus the National Risk and Disaster Management Plan, adopted in 2001, does not refer to HIV (DPC, 2001), nor does the new Multi-sectoral Strategic Plan for the Fight Against AIDS (Gouvernement de la République d'Haiti, 2007) explicitly address emergency situations. This reflection has started to take place and has led to a number of small-scale one-off initiatives, notably from UNAIDS and certain NGOs, but responsibility for ensuring that adequate steps are taken remains to be clarified within inter-governmental/donor structures and at the state level.
- Similarly, once the immediate and life-threatening stage of an emergency is over, it is left to other institutions to deal with the rehabilitation and reconstruction phase, many of which do not have the necessary resources to be able to respond adequately. There is an expectation that people will be able to find shelter with friends or relatives, and indeed, food distribution at official shelters was ended in order to encourage people to move on. However, although there are vague commitments to try to provide further assistance to people who have lost their homes and livelihoods, it is not clear to what extent the will or resources are likely to exist to be able to follow through. Some of these people may be able to recover, but most of those who have lost homes and livelihoods will be made significantly more vulnerable to HIV and other forms of adversity.
- While it is clear that strong mechanisms of solidarity do exist in Haiti and are used effectively at times like these, not everyone can be assumed to have such links and, in the light of the overwhelming impoverishment experienced by most people in recent years, there will almost certainly be limits to the extent to which families can afford to take in destitute relatives. People

who have lost both their homes and the main source of their livelihood can be considered to be extremely vulnerable to sexual abuse and HIV, particularly women and children. This is especially likely when families are broken up as a result of the adversity suffered.

- Similarly, the informal HBC mechanisms that do exist are fragile and depend on a level of well-being of the family members or carers. As vulnerability increases, people suffer further shocks, whilst at the same time being subjected to a process of impoverishment that strains their capacity to look after other relatives or community members. It is likely, therefore, that these practices will gradually be eroded, particularly in the poorest communities.
- Widespread use of reciprocity as a coping strategy in a context where most people are vulnerable to food insecurity – including in urban areas – means that targeting of PLHIV for food aid is ineffective. In most cases, PLHIV met seem to have had to share food with relatives and neighbours, with the consequence that they sometimes go hungry and may decide to refrain from taking their drugs with a consequent risk of resistance

6.2 Recommendations

- The fact that vulnerability to HIV increases during an emergency needs to be taken into account during the response: as such responses could include increased awareness-raising on the risks associated with increased transactional sex, increased availability of condoms, and even increased emphasis placed on livelihood generating activities through the encouragement of credit schemes.
- One relatively easy means of making condoms more available is to ensure that they are included in the kits that the various organisations hand out; this could be pushed by the DPC and made a requirement.
- In addition to placing condoms in kits, they need to be made available in shelters even during short-term emergencies; advance planning needs to happen to ensure that there are sufficient in stock; additionally, careful thinking needs to go into where they should be located in the shelters, who should be handing them out, etc. so that people can easily access them.
- More generally, the fact that condoms are not provided free in Haiti needs to be taken into consideration when dealing with HIV-related vulnerabilities and risks.
- During the periods that people are in the shelters, they have little to do, waiting to be repatriated; as such organisations could take advantage of many people being in the same location and carry out awareness-raising activities about HIV, including addressing stigma and discrimination.
- It would be useful if a system were established which, whilst maintaining respect and confidentiality, would enable PLHIV to come forward to ensure that any additional needs emerging as a result of the emergency (e.g. food requirements to enable ARVs) can be addressed as part of the response and rehabilitation efforts. The DPC in each department could be well placed to establish such a system; this is likely to involve special training for members of the DPC.
- Although this study did not address the issue directly, reported behaviour of some of the MINUSTAH members present in Haiti, is likely to favour HIV transmission either in the host country or at home. Currently, the lack of transparency encourages a sense of impunity so a plea is made to encourage transparency and accountability in behaviours also amongst this population.
- Finally, there are still missing information and data, as such more research is needed in a number of areas this includes the following:

    a. Whilst we have numbers of people in the evacuation shelters, little is known about those who move to stay with friends, relatives and neighbours and the resulting

vulnerabilities they face, both as PLHIV and non-PLHIV. Thus research following the lives of these people would be useful.

b. Linked to the above, we know little and do not have any accurate and current estimates of the numbers of people who have been displaced as a result of the emergencies; similarly, the numbers who continue to be displaced and who engage in cross-border activities. All this has implications for vulnerability and risk of contracting HIV. It also raises questions around what are the most effective means of providing health services in such an environment.

c. We still know relatively little about specific groups who are vulnerable to HIV and the effects of emergencies on them; this includes MSM, prison populations and street-based sex workers.

d. Whilst the various health-related services are being offered and scaled-up, people are still not coming forward; this includes PMTCT and post-rape[34] care and counselling. More research is needed to understand why women in need of such services fail to come forward.

[34] During 2004-2006, armed groups made use of collective rape to exert control over the local population.

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Annex 1

Key informants met during the course of the study

Organisation	Name	Function
MINUSTAH	Dr Ingrid Molina de Schrils	HIV/AIDS Advisor
OCHA	Manuela Gonzalez	Head of Office
	Frandy Dorvil	Officier National
UNDP	Valérie Tremblay	Spécialiste en Préparation et Réponse aux Désastres
UNAIDS	Dr Amadou Mactar Mbaye	Country Director
UNFPA	Barbara Laurenceau	Deputy Representative
	Marie José D. Salomon	Experte Nationale VIH
	Smith Maxime	Responsable Promotion groups vulnérables
Médecins Sans Frontières Belgium	Dr Marta Iscala	Medical Coordinator
	Dr Marjorie Charles	
Serovie	Steeve Laguerre	Executive Director
ASON/Plateforme des PVVIH	Jean-Sorel Beaujour	
Les Centres GHESKIO	Dr Jean William Pape	Director
Haitian Red Cross	Dr Michaëlle Amédée Gédéon	President
	Dr Myrtha Louissaint	Directrice de l'Action Sanitaire et Sociale
	Ferna Victor	
World Food Programme	Romain Sirois	Deputy Director
	Myrtha Jean Marie	HIV Focal Point
	Widline Cherichel	
Promoteurs Objectif Zerosida (POZ)	Dr Marie-Mercy Zevallos	
Ministère de la Santé Publique	Hugues Bienaimé	Chef de Service, Promotion de la santé et promotion de l'environnement
	Yannick Jean Felix	Nurse, Coordonnatrice PMTE, Hôpital Sainte Catherine, Cité Soleil
Concern Worldwide	Dr Carine Roenen	Country Director
Pan-American Health Organization	Dr Karoline Fonck	HIV/AIDS Country Officer
	Philippe Allouard	Programme d'urgence et de désastres
Comité de Gestion de Risques et de Désastres du Sud Est	Fednel Zidor	Vice-Délégué, Coordonnateur Exécutif CDGRD
	Jean Michel Sabbat	Coordonnateur Technique Département Sud Est
	Mme Germain Pierre Louis	Regional President, Haitian Red Cross
Mouvement Haïtien pour le Développement Rural (MHDR)	Strauss Védrine	
Fondation Esther Boucicault Stanislas (FEBS)	Mme Esther Boucicault Stanislas	Director
	Georges Phenol Fils-Aimé	Promoteur en sensibilisation VIH /SIDA
CCISD/PALIH 2	Martine Bernier	Coordonnatrice
Maison Arc en Ciel	Lourna Destouches	Travailleuse sociale
Médecins du Monde Canada	Dr Marie Gessy Richard Alcy	Medical Coordinator
Unité de Coordination et de Contrôle (UCC), Programme National de Lutte contre les IST et le VIH/SIDA	Dr Gédéon Gelain	Senior Consultant Epidemiologist
Direction de la Protection Civile, Ministère de l'Intérieur et des Collectivités Territoriales	Alta Jean Baptiste	Directrice
	Ing. Pinchinat Pierre-Louis	Directeur Adjoint

Annex 2

List of Focus Group Discussions, in-depth interviews and field visits undertaken

Location	Date	Activity	Group	Nos. of participants (of which women)
Centre Espoir, POZ, , Western department	15 Nov 07	FGD	PLHIV affected by violence	8 (7)
Private homes, Jacmel, South East department	17 Nov 07	IDI	PLHIV affected by floods	2 (2)
Bon Repos, Western department	19 Nov 07	FGD	Women displaced by floods	Approx. 15 (100%)
POZ Centre, Montrouis, Western department	21 Nov 07	FGD	People affected by floods	10 (5)
FOSREF Centre, St Marc, Artibonite department	21 Nov 07	FGD	Sex workers	5 (5)
FEBS, St Marc, Artibonite department	21 Nov 07	FGD	PLHIV	10 (5)
Private house, Archaïe, Western department	21 Nov 07	IDI	PLHIV affected by floods	1 (1)
Sainte Catherine Hospital, Cité Soleil, Western department	23 Nov 07	IDI	PLHIV	7 (7)