

HIV in Emergencies

Case study: Northern Kenya

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

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
BSS	Behavioural Surveillance Survey
CACC	Constituency AIDS Control Committees
CBO	Community-Based Organization
CBS	Central Bureau of Statistics
DASCO	District AIDS and STIs Coordinator
DO	District Officer
FBO	Faith-Based Organization
DC	District Commissioner
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GLIA	Great Lakes Initiative on AIDS
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
IRC	International Rescue Committee (Kenya)
IDI	In-Depth Interview
IDP	Internally Displaced Person
KDHS	Kenya Demographic Health Survey
KNASP	Kenya National HIV/AIDS Strategic Plan
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGO	Non Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OVC	Orphans and Vulnerable Children
PC	Provincial Commissioner
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexually Transmitted Infections
UNAIDS	Joint UN Programme on HIV/AIDS
UNHCR	United Nations Office of the High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WFP	World Food Programme

Executive summary

Background and context

The study was undertaken in the Turkana region of Northern Kenya in order to assess the impact of chronic drought (i.e. a slow-onset natural disaster) on HIV. This study was carried out several weeks before the post-election violence erupted. Thus, findings presented are for the period before the violence.

Turkana region has an estimated population of 550,000 people with males and females in roughly equal proportions. The region is among the least developed districts in the country (GOK 1998) and is characterized by poor infrastructure, social marginalization, flash floods, high levels of food insecurity, malnutrition and an increasingly mobile population. It also has a weak human capital base due to low investment in education. The region lies along the northern corridor – a major transport route to southern Sudan.

Amongst the Turkana, livestock production is the main economic mainstay. Other economic activities include: manual labour, weaving of baskets, fishing and small-scale businesses such as selling food snacks, operating retail outlets and selling essential commodities. A small segment of the population is involved in farming activities.

In the last two decades Kenya's arid and semi-arid lands, including the Turkana region, have experienced increasingly frequent droughts. As a result, inhabitants have inadequate time to recover from prior droughts before the next one strikes, increasing their vulnerability to food insecurity, poverty and partly to infection with HIV. Emergency here is not a "one-off" event but a sustained and continuous one. Thus, a large proportion of the population is faced with the danger of food insecurity virtually at all times.

Available data put adult HIV prevalence rates in Turkana Central at 6.7 percent (equal to the national average) as of July 2007, with rates increasing to 14 percent in some urban centres. There are an estimated 12,000 HIV-positive people in the region, and antenatal care (ANC) reports indicate that 3.5 percent of mothers attending care were tested HIV-positive. In the Turkana region 76 health facilities and seven voluntary counselling and testing (VCT) centres are found, a large proportion of which are in urban areas. Reports from the District AIDS and STIs Coordinator also indicate a very low level of anti-retroviral (ARV) uptake (an average of four people per facility).

Stigma towards people living with HIV (PLHIV) is prevalent in the region, and there is a widespread belief that HIV is a "foreign disease" affecting urban populations only. Few people know the dynamics of the disease.

Programmatic response to the emergency

Since 2000 UNICEF has been supporting the government-led emergency response coordination mechanism for health and nutrition (Ministry of Health), water and sanitation (Ministry of Water) and education (Ministry of Education). All non-state actors in the emergency response are expected to form part of a coordination mechanism. During emergencies, many United Nations (UN) agencies and non-governmental organizations (NGOs) provide immediate assistance. Organizations include the World Food Programme (WFP), World Vision, Catholic Christian Fund, International Rescue Committee (Kenya), Samaritans Purse, Merlin and Oxfam.

During emergencies UN agencies and local and international NGOs, in partnership with respective government ministries, strive to save lives and rehabilitate children in the district through a

supplementary and therapeutic feeding programme, which includes capacity building of Ministry of Health workers; according to data from the WFP field office in Turkana, up to 88,000 people are scheduled to receive food assistance between October 2007 and March 2008. Famine relief targets women because they are responsible for preparing and providing food for the family. The relief is also seen as a tool to empower them.

In 1999 the Government of Kenya declared HIV/AIDS a national disaster and established the National AIDS Control Council (NACC). It facilitated the development of the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005, which set out a multisectoral response to the epidemic guided by one coordinating authority, one M&E framework and one national strategy. Implementation of HIV interventions devolved to individual sectors and decentralized levels in order to reach affected communities, families and individuals effectively.

Contracting HIV during an emergency: vulnerabilities and resilience

In Turkana, women and their children are the first to be affected. Women encounter strong socio-cultural and institutional barriers which hinder them from effectively coping during an emergency. They also bear disproportionate burdens in caring for those who are sick with AIDS. The effects of drought lead many young women to turn to sex work as a means of survival.

Orphans and vulnerable children (OVC) are particularly vulnerable during emergencies. They are less likely to attend school, and many OVC end up being exploited by employers or resort to transactional sex as well.

During periods of adversity many pastoralists leave their families behind in search of pasture and water for animals. Their long absence increases their likelihood of engaging in extramarital (often unprotected) sex, particularly when they visit the market centres to sell off their herds. Thus they increase the vulnerability of both parties to contracting HIV, as well as to their wives when they return home.

To counter the effects of drought, people in the Turkana region are moving away from cattle herding and turning to camels, donkeys and goats, which are more resilient and can survive for long periods without water. Some pastoralists have also taken up livestock trading or growing small gardens, where possible.

The social networks established over time are crucial during the dry season. People borrow and beg for food from friends and neighbors. In addition, extended family or community members can sometimes provide those affected with casual employment or other forms of assistance.

Other survival strategies during drought situations include selling charcoal and firewood, selling animals, hunting, gathering, and adapting/restricting the diet.

In order to obtain food, some parents send pre-school children to schools where they access free food from the school feeding programmes. A similar benefit is expected by taking children to hospitals where they can obtain food in addition to other health-related services.

Vulnerabilities and resilience of PLHIV during an emergency

Children of people affected by HIV bear the burden of the emergency, often being forced to drop out of school to fend for the family and to take care of ailing parents. They face stigma and discrimination, stress and hopelessness, prompting exposure to negative coping mechanisms.

Meeting the nutritional needs of PLHIV during emergency situations is also a key challenge, and they are often not being reached by food assistance programmes because of poor targeting/selection criteria.

Social networks are important coping mechanisms during drought, as they can provide food, care, medical assistance, school fees, cash and connections to employment. Many PLHIV, however, find it difficult to cope with an emergency situation because they have lost their social network due to their HIV status and the associated stigma, discrimination and exclusion from their family and community.

Many PLHIV are rendered jobless as a result of their illness and the emergency context. Most PLHIV spoken to acknowledged receiving relief food at one point in their life, but the majority felt that the quantity was not sufficient and distribution was inconsistent.

The effects of the emergencies on service provision

Many people living in emergency-affected rural areas do not have access to health services, including HIV services (prevention, treatment and care). According to those interviewed, only about 20-40 percent of pregnant women living in rural areas have access to assisted delivery, and even major health centres suffer from inadequate staffing levels and lack of essential equipment, supplies and medicine. This increases the prospect of more frequent vertical transmission of HIV. Providing Prevention of Mother-to-child Transmission (PMTCT) services is a challenge given the nature of the emergency, which causes high levels of migration. Effective scaling up of voluntary counseling and testing (VCT) services is also a challenge, given the high levels of stigma, accessibility and volatility (sporadic violence and insecurity) in certain districts.

The drought has also had a negative impact on the provision of safe water sources for domestic, livestock and agricultural use. Communal dams and wells for livestock and homestead use are continually depleted and in some cases drying up completely; additionally, there is evidence that the water level in Lake Turkana is receding. With less and stagnating water, there is an increased risk of contamination, thereby elevating the prospect of infections, especially among PLHIV.

The emergency in the region has also had a negative effect on the ability of some families to provide basic education and material support to children. The effects of chronic drought, poverty, insecurity and cultural practices have a direct impact on education, with many children, especially girls, dropping out of school in order to help with household chores. Such practices intensify during emergencies.

Key findings

- Marginalization of the region, due to poor policies of the past, has caused the region to slide into underdevelopment characterized by high poverty levels, persistent drought, poor infrastructure, morbidity and low education levels; if not addressed up front, this combination is likely to lead to increased vulnerability of contracting HIV.
- Vulnerabilities to contracting HIV increase in emergencies owing to: a dangerous interplay of drought, insecurity, migration, transactional sex and the presence of a major transport corridor.
- A migratory pattern away from the rural areas towards the peri-urban settlements can be observed, especially among women.
- Transactional sex has increased as a result of the drought situation, with the client base shifting towards long-distance truck drivers.

- Condom use is generally low. A Behavioural Surveillance Survey (BSS) report (2004) by the International Rescue Committee (Kenya) indicates that only 58.3 percent of respondents 11-35 years of age had ever used a condom and only 15.4 percent had used one the last time they had sexual intercourse. The average number of condoms distributed per person, per month, ranged from 0.5 to 1.0.
- Stigma and discrimination directed at PLHIV are widespread, excluding them further from community support systems that are crucial for survival, especially during periods of drought. PLHIV are considered liabilities so PLHIV fear disclosing their status lest they lose social capital.
- PLHIV are unable to adequately recover from emergencies, and are increasingly becoming weak and unproductive. Even when general conditions are improving and large parts of the non-PLHIV population are making modest steps towards recovery, PLHIV are stuck in a continuing “micro-emergency”.
- For those on anti-retroviral treatment (ART), the emergency provokes abrupt movements of people, which make ART highly inaccessible, thus compromising adherence; so far there are no contingency plans to ensure people adhere to medication under fragile circumstances. In addition, lack of food often leads to people being unable to adhere to ART; this situation is common in the Turkana region, but intensifies with the escalation of the emergency.
- Faster disease progression among PLHIV who had not yet developed AIDS is commonly reported as a result of the emergency.
- The district- and national-level health implementation system is not responsive to the unique needs of PLHIV in the region. There appears to be a gap among the system and partner organizations with respect to the need to consider HIV-related vulnerabilities in the emergency response and develop specific strategies to address them.
- The recurrent emergency in the region stretches limited government and agency resources in dealing with an array of needs; this is coupled with short-term relief efforts which respond at the whim of donor interest.

Recommendations

- Any future development agenda should formulate and implement long-term policies to address food insecurity, conflict, poverty levels and infrastructure development. These policies should take into account the region’s uniqueness and foster self-reliance.
- Humanitarian response strategies should include HIV, and national strategies for the HIV response should address the specific circumstances of such (and other) emergency situations.
- HIV prevention campaigns should be intensified in the region, particularly along the main transport corridor and surrounding area. Sex workers and their clients (especially truck drivers), as well as pastoralists, should be targeted.
- Condoms need to be promoted through diverse and innovative approaches and made more readily available to the rural and urban populations, including pastoralists. One approach could be to distribute them through trained peer educators and include them in emergency kits that organizations hand out, provided this is culturally acceptable.
- Decentralizing HIV and VCT services is a priority in the region, along with the urgent need to promote the importance of these services so that people access them.
- More effective food targeting criteria for PLHIV are needed at health facilities and during general food distribution, in order to ensure that their needs are adequately addressed during emergency responses as well as during recovery periods.
- Improved monitoring systems need to be put in place to increase reliability of data on HIV.

- It is essential that stigmatization be adequately addressed. This can be achieved through intensified community sensitization activities. Using *barazas* (local administrative meetings), involving local leaders, setting up peer education programmes and working with active PLHIV support groups are important means to demystify HIV and increase knowledge.
- Stronger livelihood support mechanisms should be developed. This can be done by offering complementary livelihood activities and microfinance initiatives for pastoralists and other vulnerable groups.
- Finally, further research and advocacy work should be encouraged around HIV in emergencies, especially in reference to pastoralists, gender-based violence and coping strategies. This has the potential to inform decisions around relevant and targeted HIV prevention and service packages among these underserved communities.

1. Introduction

This country case study is part of a wider research project, commissioned by the World Food Programme (WFP), funded by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and carried out by the Overseas Development Institute (ODI), to examine the impact of different types of emergencies on HIV. The objective is to develop a conceptual framework for "HIV in emergencies" and a better understanding of the various emergency settings and their implications for people living with HIV (PLHIV) and HIV-related services and vulnerabilities.

Understanding HIV in situations of emergencies is complex and calls for caution since the application of uniform strategies may be counter-productive. Populations affected by conflict or natural disasters can become more vulnerable to HIV because of a range of factors including: poverty; displacement; food insecurity; increases in pre-existing gender-based violence (GBV); transactional sex; and the disruption of health services including HIV prevention programmes. Vulnerability can also increase due to changes in family, social or cultural norms that regulate sexual activity, leading to sexual exploitation or risky behaviours (Samuels and Proudlock et al, 2007).

Five countries were selected for field work, representing different types of emergencies and prevalence settings: Central African Republic (CAR), Haiti, Kenya, Mozambique and Sri Lanka. The countries were selected based on a number of criteria, including the kind of emergency they are facing or have faced, HIV prevalence rate and geographical location. The sites selected are as follows:

- CAR – conflict emergency, in the north
- Haiti – quick-onset natural disaster, hurricanes and history of conflict
- Kenya – slow-onset natural disaster, drought in the north
- Mozambique – quick-onset natural disaster in one site (Caia), floods preceded by ongoing drought in another site (Gaza or Inhambane)
- Sri Lanka – quick-onset natural disaster; conflict may overlap but because of another assessment to be carried out by the Office of the United Nations High Commissioner for Refugees (UNHCR) on internally displaced persons (IDPs) this will not be the focus.

For the Kenya study, northern Kenya (in particular the Turkana region) was selected mainly because it experiences slow-onset emergencies, essentially droughts. The north has also faced decades of marginalization, conflict and general underdevelopment, leading to widespread poverty.

The Kenya study was carried out between 19 November and 1 December 2007, several weeks before the post-election violence that resulted in over 1,000 deaths and the displacement of approximately 500,000 people. While there is evidence of health services being affected by the violence, including supplies of anti-retrovirals (ARVs) being disrupted,¹ findings presented in this report are for the period prior to the post-election violence and represent views with regard to the situation in Turkana region (which, in any event, did not witness an eruption of post-election violence).

The following section recounts the methodology used for the study, the organizations and individuals interviewed and the challenges faced by the researchers. Section 3 describes the country context in terms of geography, policy, history and the nature of the emergencies, epidemiology of HIV, and the livelihood and cultural contexts of Turkana region. Section 4 describes the programmatic responses to the emergencies, and section 5 explores the impact of the emergencies on PLHIV and on vulnerability to contracting HIV. The final section provides the key findings and recommendations.

¹ See various articles published by IRIN from Jan-Mar 2008: www.irinnews.org

2. Assessment methodology

The assessment was carried out by a team of two consultants. Before the field visit, the consultants worked with WFP Nairobi and field offices to identify the individuals and organizations to interview and/or visit.

Discussions and key informant interviews were held at national and district levels with government and international organizations including the National Aids Control Council (NACC), Ministry of Health (MOH), the United Nations Children's Fund (UNICEF), WFP, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Office for the Coordination of Humanitarian Affairs (OCHA). Additionally, the head of the World Initiative for Sustainable Pastoralism, as well as representatives of the Kenya Red Cross Society, Oxfam and Samaritans Purse, were interviewed.

At the regional level, discussions were held with local representatives of non-governmental organizations (NGOs) implementing HIV, health and nutrition programmes. These included Oxfam, World Vision, International Rescue Committee, Catholic Diocese of Lodwar, Africa Inland Church and Merlin.

In-depth interviews were held with community leaders and district officials as well as with PLHIV and PLHIV household members, pastoralists, sex workers and community elders. Focus group discussions were conducted with sex workers and PLHIV groups. Site visits were made to outpatient therapeutic programmes and hospital-based stabilization centres serving severely malnourished children.

A key challenge was the limited access to certain parts of the district because of insecurity and infrastructural constraints, especially in the southern part of Turkana.

There was little secondary data on, for example, the impact of drought, migration, displacement, GBV or conflict among pastoralists on the HIV situation in the region. Finding accurate data on HIV prevalence and anti-retroviral therapy (ART) uptake also proved difficult. However the research team did manage to obtain specific and localized data on pastoralists and HIV.

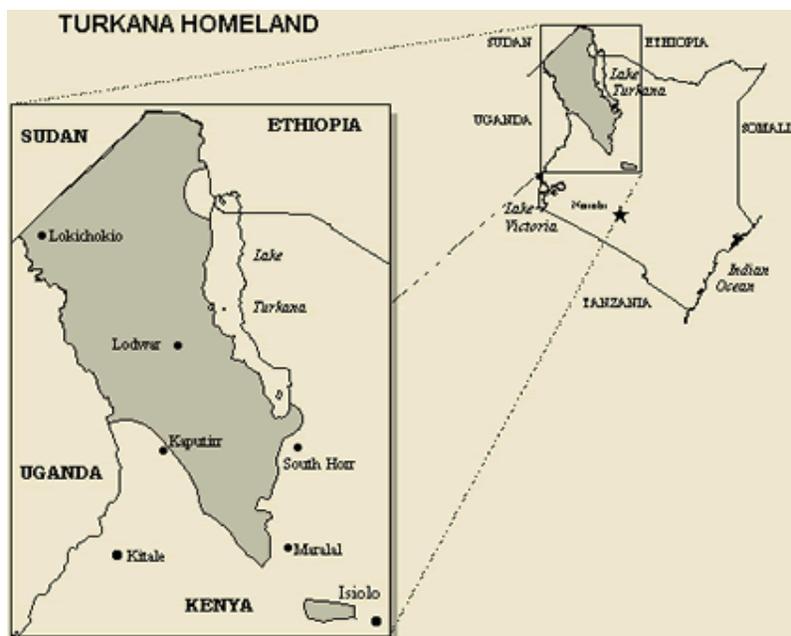
3. Country context

3.1 The Turkana region and its livelihood context

According to the Central Bureau of Statistics (CBS) key facts and figures (2006), the total projected population of Kenya in 2005 was 33.4 million, out of which 16.2 million were females and 17.2 million were males. Turkana region has an estimated population of 550,000, with almost equal percentages of males and females (50.3 and 49.7, respectively).

Since 2003 Kenya has experienced steady growth in gross domestic product (GDP). Nevertheless, poverty levels remain high.

Figure 1: Map of Turkana region



Source: www.harrisfamilymission.com

Turkana region lies in the northwestern part of Kenya and is the largest as well as one of the poorest regions in Kenya, with close to 62 percent of its population living below the national poverty line (CBS, 2004). The region is semi-arid, with erratic rainfall patterns and frequent droughts and famines. The area is also characterized by poor infrastructure, social marginalization, flash floods, high levels of food insecurity and malnutrition, and an increasingly mobile population. It also has a weak human capital base due to low investment in education: the region has one of the lowest primary school enrolment and completion rates in the country. Enrolment rates in primary schools as of 2003 were 31.6 percent for boys and 24.2 percent for girls.

The region lies along the northern corridor – a major transport route to southern Sudan. The volume of traffic has increased since the signing of the peace accords in Sudan, which has opened up the transport corridor to a flurry of activities. Many non-indigenous peoples have settled in the region, serving the transport sector and other service industries.

Internally, Turkana borders a number of local communities including the Pokot, Samburu, Marsabit and Baringo. Some of these communities have a history of hostility with the Turkana, which is aggravated by arid land and consequent competition for scarce resources.

The region also has a mix of cultures owing to the presence of many local and international organizations that provide services and relief operations to the host community and refugees from different countries. The Kakuma Refugee Centre, one of the largest refugee camps in northern Kenya, is located here: the closure of numerous refugee camps across Kenya since 1992 and the transfer of refugees from camps in the coastal and northeastern provinces have turned Kakuma into a multinational community providing a home to over ten different African nationalities as well as over 20 ethnic groups from Burundi, CAR, Democratic Republic of Congo, Eritrea, Ethiopia, Rwanda, Somalia, Sudan Tanzania and Uganda. Currently, Kakuma shelters 91,500 refugees. About 21.5 percent of the total populations in the camp are women and girls below the age of 25 years, who are considered most vulnerable to sexual exploitation and abuse. Refugees from Sudan are currently being repatriated in the wake of the signing of the peace accord.

The wider area of the Rift Valley province in which the Turkana region lies is described as the “breadbasket” of Kenya and is where most wheat and maize is grown. Among the Turkana, however, livestock production is the main economic mainstay. A gender division of labour is

apparent: men do the herding, while women build houses and fences, clean the animal sheds, milk cattle and goats, feed and provide them with water, and skin animals and sell the hides. Women also conduct the household tasks: fetching drinking water and firewood, cooking and child rearing (Anderson and Brouch 1999). Some are also involved in manual labor, weaving baskets, fishing, and small-scale businesses such as selling of food snacks, operating retail outlets and selling essential commodities. A small segment of the population is involved in other agricultural activities, such as farming. Most economic activities are conducted for daily survival and do not allow any form of savings or investment.

There is evidence that pastoral communities are experiencing rapid and unprecedented changes in their livelihood system, which are exacerbated by the drought situation: reduced production capacity (livestock numbers have not grown in the past 30 years) and reduced availability of natural resources, combined with a population increase. Moreover, their capacity to adapt has been tested to the limits. Given these changes, pastoralists have become vulnerable, not only to HIV but also to disruption of their wider livelihood stability.

In the context of these changes and the impact of the drought situation, women have borne the brunt: they are working more, including looking after the sick and weak and find it harder to care for their children. Drought, and the resulting threat to or loss of livelihoods, has also led to an erosion of roles associated with the pastoralist lifestyle, leading to an increased influx of pastoral groups into the peri-urban settlements in search of work or food aid – this change has seen pastoralists rely more on consumer goods.

3.2 Epidemiology, health and nutrition

HIV spread rapidly in Kenya during the 1990s, reaching prevalence rates of 20-30 percent in some areas. National prevalence declined significantly from a peak of about 10 percent to under 7 percent in 2004. This trend is supported by data from national surveys which document changes in behavior toward fewer partners, less commercial sex, greater condom use and later age at first sex. The Kenya Demographic Health Survey (KDHS) 2003 revealed that 6.7 percent of adults tested are infected with HIV. Reconciliation of KDHS and sentinel surveillance data gives an adjusted prevalence of 7 percent, implying that 1.1 million adult Kenyans are infected with HIV, of whom about two thirds are women. In addition, 100,000 children are estimated to be living with HIV (KNASP, 2005).

The gender difference is most pronounced among young people; in the 15-24 age range, female prevalence is nearly five times higher than male prevalence. Prevalence rates also show significant rural/urban variations, with average urban prevalence (10 percent) nearly twice that of rural areas (5-6 percent).

With regard to ARVs, in January 2002 the National AIDS and STI Control Programme (NASCO) established the national ART task force to guide the way to scaling up the provision of ART across the country. The policy involves both the private and public sectors. Kenya has made significant progress in institutionalizing care and treatment and has opened 288 comprehensive care centres, of which 167 are in government facilities; this includes all provincial hospitals, all district hospitals, most sub-district hospitals and some health centres. The MOH also has a reasonably well developed programme for the prevention of mother to child transmission (PMTCT) using nevirapine. In addition, all regions of the country now have access to some facilities for voluntary counselling and testing (VCT), but these are still inadequate and tend to be concentrated in urban areas (WHO, 2005).

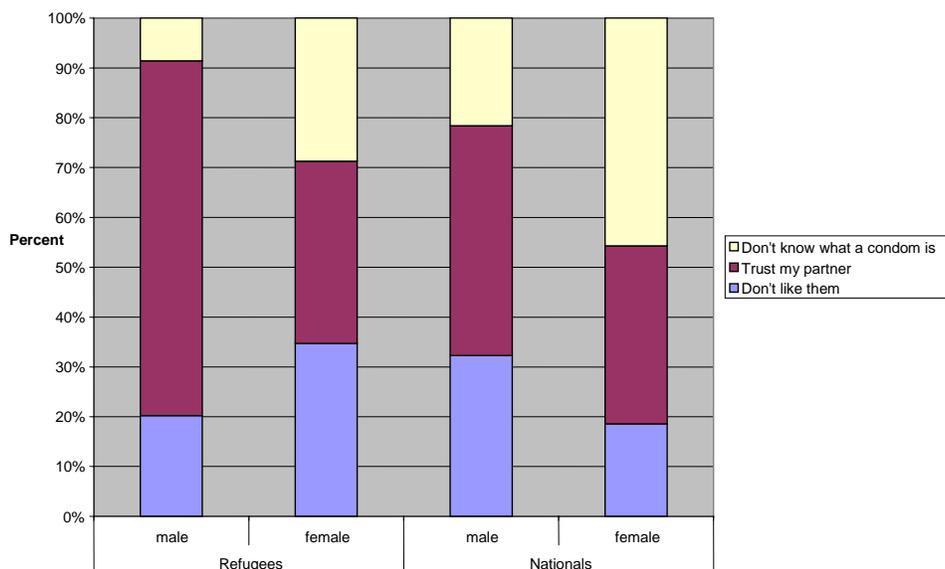
In Turkana region, there are 76 health facilities and 7 VCT centres. In 2001 and 2002, HIV sentinel surveillance on antenatal mothers and sexually transmitted diseases showed a prevalence rate of 13 percent and 18 percent, respectively (NASCO & MOH, 2003). Data from the District AIDS and Sexually Transmitted Infections Coordinator (DASCO) in Turkana Central puts the prevalence rate at 6.7 percent as of July 2007, with the rate increasing to 14 percent in some urban centres. There are an estimated 12,000 HIV-positive people in the region and antenatal care (ANC) reports

indicate that 3.5 percent of mothers attending care were tested HIV-positive. This may not be indicative of the true situation on the ground given inconsistency and uptake of ANC services. The reports from the DASCO also indicate a very low level of ARV uptake (an average of four people per facility). In Turkana Central, an estimated 2,883 people require ARV, but only about 300 people are on ARV. Due to the remoteness and mobility of certain groups, access to ARVs is extremely difficult (NASCO, 2007).²

According to a 2004 Behavioural Surveillance Survey (BSS) report on Turkana, a high percentage of the population has low levels of knowledge about HIV and 87.5 percent and 88.9 percent of 15-24 and 25-49 year olds, respectively, reported engaging in unprotected sex. As is the trend nationally, women are particularly vulnerable to contracting HIV due to circumstances that lead them to engage in high-risk sexual behaviour. A total of 243,532 condoms were distributed in 2004. The average number of condoms distributed per person, per month, ranged from 0.5 to 1.0. The distribution level was below the minimum expected during a post-emergency situation, i.e. one condom per person, per month (Spiegel and Toure, 2004).

The graph below indicates some of the reasons why condoms were reportedly not used in the last sexual encounter as reported by Spiegel and Toure.

Graph 1: Primary reason why condom not used with regular partner

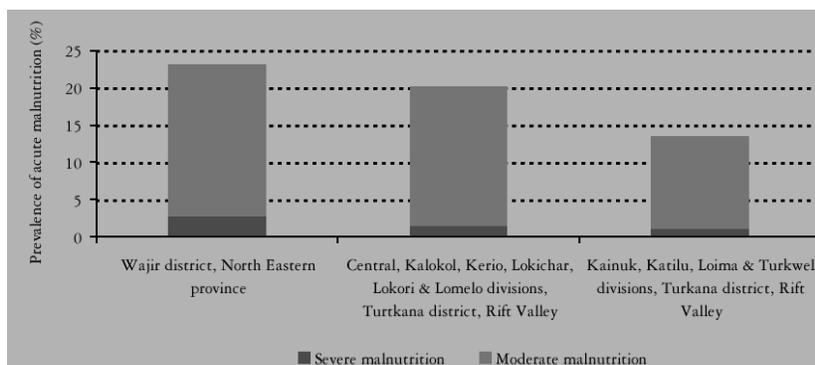


According to MOH/NASCO (2006), “In Kenya, about 31 percent of children under five years old are stunted (too short for age) and about 20 percent are underweight.” Rates of underweight and stunting are approximately 10 percent higher in rural areas than in urban areas. In addition, anemia affects three out of every four children under five years; one out of every two women of reproductive age; and one man out of every five. About half of Kenyan children under five years old, and women of reproductive age, are also at high risk of zinc deficiency. Vitamin A deficiency remains prevalent among children and women. Vitamin A, zinc and iron deficiencies underlie widespread multiple micronutrient deficiencies that constitute significant public health problems (MOH 1999). It is estimated that over 23,000 deaths of children are associated with increased susceptibility to infections related to vitamin A deficiency, and that approximately 70 percent of children in Kenya grow up with lowered immunity. Overall, the nutritional situation of the Kenyan population remains precarious.

²It should be noted that obtaining accurate data for estimating prevalence is a daunting challenge given the mobility of the population, the vastness of the region and the security concerns.

According to the KDHS (2003) 24 percent of children under five in the Rift Valley are underweight, 32 percent are stunted and 8 percent are wasted. The situation in arid areas is more severe, and in Turkana, as indicated below, even as of September 2007, up to 20 percent of the population suffered from some form of malnutrition. The effects of food insecurity in all districts in Turkana are compounded by poor infant/young child feeding practices, morbidity and high levels of poverty.

Graph 2: Prevalence of malnutrition in Turkana district, September 2007



Source: Merlin Nutritional survey, September 2007

Similarly, a UNICEF survey shows that acute malnutrition rates are dangerously elevated in all parts of Turkana. “The level of malnourished children in this district is quite high,” says UNICEF nutritionist Emily Teshome. HIV/AIDS has worsened the condition of malnourished children and pregnant women in the region, with acute malnourishment in parts of Turkana reaching as high as 20 percent above the World Health Organization's critical point of 15 percent. Hospitals in Turkana are struggling to provide treatment to the huge number of undernourished children who stream through their doors every day. District health systems lack the capacity to detect and manage malnutrition according to international standards (UNICEF, 2006). Health conditions in drought-affected areas usually become very serious. More often than not, this results in seasonal and unpredictable increases in malnutrition.

3.3 History of the emergency

In the last two decades, Kenya's arid and semi-arid lands have experienced increasingly frequent droughts. As a result, inhabitants have inadequate time to recover from one drought before the next one strikes, increasing their vulnerability to food insecurity, poverty and partly to infection with HIV. Emergency here is not a “one-off” event but is sustained and continuous. Furthermore, the region experiences what may be referred to as “social drought”: not only the climatic shock, but various internal and external factors (state, relief) undermine the population's capacity to adapt to hardships and changing situations. The high presence of aid and humanitarian agencies in the area can disrupt the social fabric, since people considered as providers and heads of household are turned into dependants, hence losing whatever authority they held. One informant explained, “Food aid is damaging in regard to power relations. Elders no longer have powers to control community activities, including giving out food.” Food aid can also interfere with the long established survival strategies, thus potentially creating dependencies on external assistance.

It is difficult at times to distinguish between the risks of drought and non-drought periods: during the rainy season, floods often destroy the little farming practiced along the rivers, and cattle die from disease. In the dry season, water is scarce and cattle die of starvation and dehydration. Many people also suffer from diseases during these periods. Thus, a large proportion of the population is faced with the danger of food insecurity virtually at all times, and the mainstay of the Turkana's economy – livestock – is under constant threat.

As a result the region has had to contend with high levels of poverty, upsurge of diseases, poor sanitation and increasing marginalization. This is likely to set the stage for increased risk of infection with HIV or other sexually transmitted infections (STIs) for women and men. Sexual exploitation and using negative coping mechanisms such as transactional sex, begging and banditry seem like viable options to many. Moreover, condom use is generally low; if women engage in transactional sex to survive, the chances are very high that they cannot negotiate safe sex.

3.4 Cultural context

Cultural and social practices such as polygamy, wife inheritance and early marriage are still practiced in different parts of the region. Cases of very young girls (12-15 years old) getting married are common. Some of these practices have been closely associated with the spread of HIV infection. A community elder made the following observations: "...I doubt it if many people are using condoms... when my own sons died I told people to be patient and not inherit their widows because we did not know the cause of their death, but surprisingly it did not take long before they were remarried...I would say wife inheritance and polygamy are a big problem."

There is also increasing worry among Turkana elders about the steady erosion of their culture and traditions due to urbanization as young people move to settlements and towns, attracted by images of "modernity". This has created a clash with traditional Turkana culture, values and authority. For instance, elders who used to wield social and economic power and provided solutions in crisis situations are almost powerless. This position of authority has been taken over by relief agencies and the state, undermining traditional Turkana hierarchal authority. Additionally, as different groups of people migrate to and converge in urban centres to access relief assistance, physical and socio-cultural separations are created between them and their family. According to one informant, for these groups "it is easy to remove moral codes that govern one's actions," often resulting in unprotected transactional or consensual sex.

During discussions with PLHIV and caregivers, it was evident that communities' perceptions of those infected and/or affected were skewed: accusing fingers were often pointed at women. One woman, like many others interviewed, recounted, "I was forced to move out from my marriage and leave behind my children because my husband and his family lay blame on me for bringing the disease."

Issues around stigma are augmented by the widespread belief that HIV is a "foreign disease" affecting urban populations only. Few people know the dynamics of the disease. This attitude was reflected in the in-depth interviews with pastoral groups. Also, key informants exhibited a poor knowledge base about HIV, its transmission routes and treatment. This is in line with other studies by Oxfam and Merlin which indicate that nomadic pastoral households had poor HIV-related knowledge in terms of transmission, prevention, condoms and ARVs; for example, 61.7 percent of men and 40.7 percent of women believed that HIV/AIDS was found only in towns (Oxfam and Merlin, 2005).

4. Programmatic responses

In 1999 the Government of Kenya (GOK) declared HIV/AIDS a national disaster and established the National AIDS Control Council (NACC). It facilitated the development of the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005, which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within the government, civil society, the private sector and development partners.

According to the KNASP 2005/06-2009/10, Kenya is committed to the "Three Ones" principle: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national HIV/AIDS coordinating authority with a broad-based multi-sectoral mandate; and one agreed country-level monitoring and evaluation system. The concepts of national ownership, multi-sectorality, mainstreaming, harmonization and coherence have been combined in these principles, which aim to increase the pace of the HIV/AIDS response and promote more effective use of resources by clarifying relevant roles and relationships (KNASP, p 2).

Since 2000 UNICEF has been supporting the government-led emergency response coordination mechanism for health and nutrition (Ministry of Health), water and sanitation (Ministry of Water) and education (Ministry of Education). All non-state actors in the emergency response are expected by the government to form part of a coordination mechanism. During emergencies, many UN agencies and NGOs provide immediate assistance. They include WFP, UNICEF, World Vision, Catholic Christian Fund, International Rescue Committee, Samaritans Purse, Merlin and Oxfam.

During emergencies UN agencies and local and international NGOs, in partnership with respective government ministries, strive to address the acute situation to save lives and rehabilitate children in the district through implementation of a supplementary and therapeutic feeding programme, which includes capacity building of MOH workers. The relief organizations provide maize, beans and cooking fat to each registered family. According to data from the WFP field office in Turkana, up to 88,000 people are scheduled to receive food assistance between October 2007 and March 2008. Famine relief targets women because they are responsible for providing and preparing the family food, and it is also seen as a tool to empower women. In addition, women are registered because they remain at campsites when migration takes place.

In Turkana, various government departments in partnership with UN agencies, local and international NGOs and community- and faith-based organizations (CBOs/FBOs) have over time been actively involved in the emergency response, which has primarily been concentrated on drought-related mitigation. Following are descriptions of the roles played by these actors in response to the epidemic.

4.1 Government agencies

Government departments are in touch with the communities through various offices and have a long-standing knowledge of the pastoral systems as well as the challenges facing different communities. These offices are represented from the grassroots to the national level; at the lowest tier are the village elders followed by the area chiefs, who are answerable to the district officers (DOs), district commissioners (DCs) and provincial commissioners (PCs) in that order. With respect to HIV, most government departments and offices have mainstreamed HIV/AIDS in their operations. However, this effort is hampered by bureaucracy and inadequate funding.

The Constituency AIDS Control Committee (CACC), which is the district-level HIV/AIDS response arm under the NACC, is mandated to coordinate the multi-sectoral approach to fight the epidemic. Members of CACC in Turkana Central are drawn from up to 30 different sectors, including government, private sector, NGOs and PLHIV representatives. The office is conversant with HIV/AIDS dynamics in the district and is fully aware of the challenges posed by HIV/AIDS, including the disruption of livelihoods, its relationship with orphans and vulnerable children (OVC), and the need to target PLHIV in food aid allocation. However, translating this awareness into action is an uphill struggle.

On its part, the MOH offers preventive and promotive services (treatment and care for PLHIV), condom distribution, and support to sentinel site surveillance and data gathering through the DASCO in partnership with UN agencies and NGOs. However, these activities are concentrated in urban centres, with minimal contact made in rural areas.

4.2 Non-governmental/faith-based organizations

The UN agencies, NGOs and FBOs have had a long history in the district and some have come to fully understand the complexity of the communities' needs. According to observations made by Sister Margaret, the medical co-coordinator of the Diocese of Lodwar, any meaningful development work needs to take a bottom-up approach, otherwise "an increasing number of people will continue to depend on relief food." She added, "Sometimes NGOs come over but implement donor activities without taking into account what has been built over the years...some organizations just impose things without taking into account people's socio-economic and cultural activities. Too often help that comes here undermines people's ability to work and build their own livelihoods." Other agencies spoken to (e.g. Merlin, Oxfam and World Vision) share in the sister's concerns that sustainable change can only be achieved through people's participation and involvement.

The main areas of interest to many of the agencies are peace and reconciliation, relief food distribution, food security, education and health services. Most of these activities have directly or indirectly mainstreamed HIV/AIDS programmes, while others are in the process of doing so. Organizations such as Merlin, Oxfam, IRC, World Vision, Samaritans Purse, UNICEF and Diocese of Lodwar, among others, have mainstreamed HIV/AIDS in their activities. Many support HIV/AIDS programmes within the region. However it is important to note that HIV/AIDS services arrived in the region on the back of the emergency relief operations – according to some NGOs allocation of resources targeting health services is disproportionate, undermining holistic medical care.

4.3 PLHIV groups

Although these groups are present, at community level they are few in terms of number of support groups and/or people per group. They are also weak in terms of capacity: HIV/AIDS-related activities are limited or almost absent due to lack of material and financial support.

According to the CACC representative, Mr. Emaniman, since 74 percent of the people in the district are considered poor, "putting food on the table is the challenge for most families, more so for individuals and families affected by HIV/AIDS." He added, "Many people visit our offices in the hope of getting material help or food."

Findings from the study show that there is a general but vague acknowledgement of the unique place of HIV/AIDS in the wake of the emergency situation. A uniform set of national HIV guidelines are applied without taking into consideration emergency-driven factors likely to increase the risk of HIV. It is clear that while there has been a concerted effort to respond to HIV/AIDS in the region, many issues remain unanswered. As noted in section 3.3, it is difficult to distinguish between emergency and non-emergency periods, which presents further challenges in distilling targeted responses. Drought, insecurity, floods, migration and displacement are permanent features, and are increasing in intensity. While it is recognized that HIV dynamics and challenges in drought-affected Turkana differ from other regions, government and its partners have yet to adapt and implement appropriate HIV interventions. HIV/AIDS-related concerns are not yet a routine part of emergency operations. An escalation of any of the aforementioned emergency features is dealt with separately from HIV. Generally most organizations consider HIV as an emergency but not HIV *in* an emergency.

5. Effects of the emergency

5.1 On vulnerable groups

5.1.1 Vulnerability

The slow-onset emergency in northern Kenya affects people in a variety of ways and is a significant contributor to increasing their vulnerability to HIV infection. Women and their children are the first to be affected, as women encounter strong socio-cultural and institutional barriers that hinder them effectively coping during the emergency. They also bear disproportionate burdens in caring for those who are sick with AIDS. They are also less likely to cope with the impact that the drought has on their livelihoods because of traditional gender roles and lack of education.

There are indications that women may become infected through sexual contact more easily than men and that they tend to become infected at a younger age. Young girls in Turkana are often sent to urban centres to sell milk or firewood. In these circumstances it is likely that they engage in consensual sex or are forced into early sex. It is also observed that the effects of drought lead many young women to turn to sex work as a means for survival. A 23-year-old PLHIV interviewed explained, “You can see around here [Lodwar] that many young girls have started prostitution... some would have sex for as little as fifty shillings [~US\$ 0.60] because of problems back at home.” Another high-risk alternative during the emergency is to move closer to relief food distribution points and position oneself around local hubs where clients for sex work are likely to be. One commercial sex worker said, “Many young girls engage in prostitution because of the drought situation. These people are hungry and their families have nothing to eat so they start this (prostitution) to help their families... some of these girls are very young.”

Commercial sex workers mentioned that the client flow fluctuates with seasons, with fewer clients being available during severe drought. This requires the sex workers to quickly move to the nearest urban centres along the transport corridor, where the search for a “new customer base” intensifies. They also stated that when there is a scarcity of clients, they are more likely to have unprotected sex. As one commercial sex worker said, “If we miss clients, then that is a drought to us...but during droughts we have few clients and getting money is difficult, so condom use is unlikely. When many clients are available we use condoms because if somebody refuses to put one on then you are assured of getting another client.”

Clearly children bear the burden of the emergency in a number of ways. For example, when one or both parents are infected with HIV, children are often forced to drop out of school to fend for the family and to take care of their ailing parent(s). These unique demands pave the way to stigma and discrimination, stress and hopelessness, prompting exposure to negative coping mechanisms. The many accounts of those interviewed reveal how many young children, especially girls, are marginalized as a result of HIV/AIDS.

The consequences of the emergency are also far-reaching for OVC. Orphans are especially vulnerable to social and health risks: they are less likely to attend school and may live in households where conditions are less favourable for health and development in general; in some cases they have had to step in as head of household. Many OVC, upon losing parents, end up being exploited by employers. Similarly, those engaging in sex work are likely to be exploited by their clients. A leader of the Youth to Youth organization described the situation: “OVC find it very hard. Some live with relatives who tell them to go and work, many don't go to school, and some head their households and sell sex or beg in the streets so as to take care of their siblings.”

During periods of adversity many male pastoralists leave their families behind in search of pasture and water for animals. Long absences increase their likelihood of engaging in extramarital sex. It has been reported that given the difficult conditions, they sometimes visit the market centres to sell off their herds. With money in their pockets, they engage in (often unprotected) sex with female sex

workers, clearly increasing the vulnerability of both parties to contracting HIV, as well as to their wives when the men return home.

Depletion of assets also takes place among those who undertake other economic activities such as fishing, farming and small-scale businesses. In most urban centres the situation is grim. As a result, loss of livelihoods often leads to tensions within families, and even family break-ups, in which case women and children are usually affected the hardest and left further marginalized.

5.1.2 Resilience

Among pastoralists, coping with the emergency is indeed a challenge. Livestock is their only source of wealth, but drought has depleted, and often decimated, stocks. Drought has also promoted animal diseases and weakens animals since they often have nothing to feed on. To counter effects of drought, more people are turning to camels, donkeys and goats, which can survive for long periods without water. Other pastoralists have also been forced to learn other survival techniques like buying and selling livestock or cultivating small gardens. During the urban-based interviews, it was mentioned that signs of certain livelihood activities are an indication of impending drought. As the leader of the Ngiturkana PLHIV group stated, “When you see many people selling charcoal and firewood, then you should know that there is a likelihood of a drought...next you will see goats being sold, and this is a sign that things are not good.”

Traditionally, residents here have resorted to community social networks to assist them to cope with drought. The social networks established over time are used during the dry season to obtain food. People borrow and beg from friends and neighbors, and relatives will provide formal or casual employment. In addition, wealthier people will lend cattle. This is a traditional mutual support system among the Turkana, whereby those who are better off at the moment help the poorer ones through restocking and thus prevent them from “dropping out” of the pastoral system altogether. However, it is clear that, over time, the effects of the emergency diminish the ability of pastoralists to help others, since most people are eventually affected.

One coping mechanism for some parents is to send pre-school children to schools, where they can access free food from the school feeding programmes. Where take-home rations are provided to the children, they are shared with the rest of the family. In other instances, children are taken out of school to search for water and pastures. One health care worker in Kalokol explained, “During periods of extreme drought, very young children are taken to school in the hope of benefiting from school feeding programmes...but during the rainy season children are taken out again.” Parents also take their children to hospitals, hoping for a similar benefit of food in addition to other health-related services. According to sister Margaret of Lodwar Catholic Diocese, “Some people are so desperate for food that they wish their children were HIV positive so as to benefit from relief food... one woman brought her child to be tested at three different times hoping she would turn out positive so that she could benefit from therapeutic food supplements targeting HIV-positive children.”

Other survival strategies include hunting, gathering and adapting the diet. In pastoral communities, people rely on wild fruits (edung, erut, egol and edapal) as supplementary food sources in times of emergency;. Animal blood and, to a lesser extent, milk form an important part of the pastoralists’ diet during these times. Migration to peri-urban and urban centres in search of work or relief assistance is also an important coping strategy during periods of drought.

A respected community elder made the following remark in relation to economic activities undertaken by residents of the region: “The Turkana are among the strongest people created by God...we are surrounded by hostile communities, the weather conditions are harsh throughout the year, there is no water, we walk long distances to the markets, but somehow we manage to survive. Our only natural resources here are the mkoma tree used for weaving baskets and Lake Turkana. These to us are like our only farms.” This shows the precarious balance between scarce natural resources and harsh conditions on the one hand, and economic survival and maintenance

of livelihoods on the other. While people are used to hardships, their traditional coping mechanisms seem exhausted in the face of the ongoing emergency situation.

5.2 On PLHIV

5.2.1 Vulnerability

Meeting the nutritional needs of PLHIV is a challenge to most relief agencies. Relief food distribution faces logistical and administrative problems, and often the needy, including OVC and PLHIV, are not reached because of poor targeting/selection criteria. As a result PLHIV have to rely on hand-outs from family or friends. Most PLHIV admit facing difficulties when continuously asking for food from relatives or friends, since they too are experiencing their own problems. Moreover, whatever food is obtained is shared among family members. A PLHIV who is a beneficiary of a supplementary food programme in Kalokol said, "I cannot go to my brother every time to ask him for food. He also has his problems...my children are affected because I share with them the little that I get from hospital... I would not say that the food is a lot. We are barely surviving."

In comparison to other groups, PLHIV do not have the social support networks that others rely on during emergency, since stigma excludes them, especially when HIV becomes noticeable. Hence PLHIV do not only lose their assets, but unlike the rest of the population they also lose social capital. They are sidelined in community activities because their ability to acquire food and compete for scarce resources is overly compromised by frequent illness.

This situation was aptly described by a youth leader, who observed widespread stigma in the region. He said, "Stigma and discrimination are rampant here...some think that you can get HIV by greeting someone. If you lose weight, people look at you differently. PLHIV particularly have hard times during severe droughts." During interviews, PLHIV confirmed these claims. The first woman in Turkana Central to publicly disclose her status in 2005 explained, "I have been severely discriminated against by my husband's family and my own family. Even my children are discriminated against. My house has been burnt down because of being discriminated against...my neighbors don't take me as a human being, they don't talk to me and when I recently started selling fish nobody wanted to buy fish from me."

Under these circumstances, one striking condition shared by PLHIV is that of further marginalization. Their decision-making power and control over resources are undermined because of stigmatization, and their reliance on other people diminishes their ability to have a stake in resource utilization.

There is also a heavy burden on HIV-positive mothers who are unable to access health facilities. They may have to breastfeed their children, increasing the children's risk of contracting HIV. Some HIV positive mothers do not have the necessary information regarding PMTCT, and the emergency may pose increased difficulties in accessing this information from health centres. Additionally, once children are infected, they require specific care and support services, which may also be difficult to access during drought situations. As one HIV-positive mother said, "During the drought, things are difficult. For instance, I used to breastfeed my baby a lot because many times there was nothing to give the baby...I wish the doctors had told me about PMTCT early so that I could have saved my child from this problem."

PLHIV with no source of income complained that the disease takes its toll on them either because they have little or no food at all. Particularly those on ART complained of having to take the "strong" medication with little or nothing to eat. ARV drugs have sometimes been called "death drugs" because of the effect they have on patients who take them without adequate food, according to a volunteer with the Kenya Red Cross (IRIN/Plus, 2007). For those on treatment, it is challenging to adhere to their ARV medication regime. The safety and effectiveness of the drugs

depend on the food intake. One PLHIV interviewed said, "...the ARVs are strong and at night if you sleep on an empty stomach, you wake up feeling very weak – it's like you have been doing some heavy work. Taking ARVs is a big problem, especially for those of us who often don't have food."

5.2.2 Resilience

Residents in this region engage in economic activities that intensify in number and magnitude during emergencies as people struggle to cope with adversity. Findings from this study have revealed that PLHIV engagement in economic activities is limited since their participation is dependent on asset availability, well-being and a supportive social network. Usually one or more of these factors has been weakened, making PLHIV more vulnerable and often resulting in further impoverishment.

The social networks established previously or during the drought are important coping mechanisms for many PLHIV. People here have learnt to establish and strengthen social networks with relatives, friends, churches, health centres, NGOs and schools. These networks provide food, child and elderly care, medical assistance, school fees, cash and connections to employment. In most cases, family and friends who do not stigmatize are turned to for support.

During extreme difficulties people stay with relatives and friends in other urban or rural areas. Some HIV-positive individuals send their children to stay with relatives because of poor health and diminishing resources caused by the emergency.

The following activities were mentioned by PLHIV interviewed as the most common forms of livelihood activities in which they are currently or were previously engaged. However it should be noted that many others are rendered jobless:

- Providing domestic services for wealthier families
- Fetching water and firewood/exchanging labour for food (common among the host community and refugees in Kakuma)
- Weaving baskets, mats and hats from leaves of the drought-resistant plant mkoma
- Working as bar maids
- Selling local brew
- Engaging in sex work
- Buying/selling cows from rural to urban centres (done mostly by pastoralists and middlemen)
- Conducting manual labour in towns (loading/unloading food from trucks, serving as *touts* on mini-buses)
- Working as security guards in towns (e.g. Lodwar, Kalokol and Lokichogio)
- Fishing in Lake Turkana and preparing fish for sale (seasonal)
- Selling food snacks near homes and at local market centres.

Most PLHIV spoken to acknowledged receiving relief food at one point in their life. But the majority felt that the quantity was not sufficient and distribution was inconsistent; none reported relying on it exclusively. On the other hand, some informants felt that food distributions could undermine the ability of people to work and build their own livelihoods, and that their ability to be innovative and productive might diminish. According to the Diocese of Lodwar medical coordinator, "There seems to be a dependence of people on help around here. Rather, people should be facilitated to help themselves. Food should only be given to the most vulnerable groups including HIV-positive people."

The study found that one commonly applied coping mechanism for most PLHIV is to move closer to urban settings. The very weak, and individuals who have lost their livelihoods, relocate to peri-urban or urban settings where they may have easier access to support.

5.3 On service provision

5.3.1 Health services

The region faces numerous health-related problems, including malnutrition, malaria, HIV, tuberculosis and high levels of infant mortality due to HIV-related complications and outbreaks of diarrhoea. Health surveys in March/April 2005 and July 2005 showed that 62 percent of deaths among under-five children in northwest Turkana resulted from fever and malaria, 28 percent from coughs and difficult breathing and 10 percent from diarrhoea (UNICEF Humanitarian Aid Action Kenya, Kenya Update, 6 Oct 2005). This places additional pressure on already overstretched health services that are coping with staff shortages, poor equipment and drug stock-outs. Despite the high need of regions such as Turkana, a large number of people living in emergency-affected rural areas do not have access health services, including HIV services (prevention, treatment and care).

According to those interviewed, only about 20-40 percent of pregnant women living in rural areas have access to assisted delivery, and even major health centres suffer from inadequate staffing levels and lack of essential equipment, supplies and medicine. This increases the prospect of more frequent vertical transmission of HIV in a region which, according to NASCOP (2007), has 436 children who are on ARV, 2,512 requiring cotrimaxazole and 26,818 who are orphaned. Providing PMTCT services is a challenge since emergencies cause large-scale displacement. Many deliveries are conducted at home because of the distances to the nearest health facility, and fear of violence or raids en route. This trend is likely to increase with worsening food shortages and general socio-economic distress.

Providing adequate voluntary counseling and training (VCT) services is a challenge given high levels of stigma, accessibility and volatility/insecurity in certain regions. Many people simply do not access these services. A survey by Oxfam and Merlin (2005) to assess knowledge, attitudes, practices and behaviours of the communities in northeast Turkana with respect to HIV/AIDS and STIs showed that only 2.2 percent of respondents have ever tested for HIV – in Lapur the figure was only 0.9 percent. Only 31.3 percent have ever heard about VCT, and only 16.4 percent could correctly describe the services offered in a VCT centre.

The same study showed relatively low condom awareness (58.8 percent), with 54.1 percent of female respondents and 63.9 percent of male respondents being aware of the male condom. As already noted, Spiegel and Toure (2004) found similar results among the refugees in Kakuma and the surrounding host population. In their study, only 15.4 percent of respondents reportedly used a condom during their last sexual intercourse. Low condom use was confirmed by those interviewed, especially in rural areas. According to the head of the Kalokol AIC health centre, "It takes very long before the condom dispensers need to be refilled...I don't think many people use condoms here. Our dispenser is hardly re-stocked because no one uses them ...probably low condom use in this region could be attributed to cultural beliefs and low formal education."

5.3.2 Other basic services: nutrition, sanitation, education

According to a UNICEF official, "The perception that children from Somalia form the bulk of the malnourished children may not be true...many Turkana children are affected and enrolled in supplementary and therapeutic feeding because of the effects of drought." Data on admissions for inpatient and outpatient therapeutic feeding programmes (2004 and 2006) show increases in admissions in 2006. This can possibly be attributed to the drought situation or as a result of expansion of services.

The drought has also had a negative impact on water sources for domestic, livestock and agricultural use. Communal dams and wells for livestock and homestead use are continually depleted and in some cases dried up completely. There is also evidence that the water level in Lake Turkana is receding. This has an effect on sanitation and hygiene, since with less and

stagnating water, the risk of contamination increases, thereby elevating the prospect of infections, This is particularly true among PLHIV, who are at greater risk of acquiring illnesses.

The emergency in the region has also had a negative effect on the ability of some families to provide basic education and material support to children. According to respondents, the effects of chronic drought, poverty, insecurity and cultural practices have a direct impact on education, with many children, especially girls, dropping out of school in order to help with household chores. This practice intensifies during emergencies.

6.Key findings and recommendations

The boundaries between the "emergency" and the "normal" situation are not as clear as in other emergency types (rapid-onset natural disaster, conflict/post-conflict) since in a slow-onset emergency, livelihoods are always under a certain threat. The factors may be the same, but their impact is amplified in extent and quality. This leads to a crippling of traditional community and household solidarity mechanisms, and also to a "squeeze-out" effect, whereby PLHIV are considered even more of a burden, and are further marginalized and often excluded from support and social networks.

In the context of the emergency in the north, it is important to view the drought in its social context, a context in which, amongst other things, emergencies have undermined traditional family and community cohesion. Traditional capacities and patterns of protection and care have been destroyed, placing women and children at heightened risk of exploitation, and physical and psychological trauma. The effects of these emergencies have been heavily felt over the last several years, resulting in high levels of food insecurity, malnutrition, poverty, displacement and banditry.

6.1 Key findings

- Marginalization of the region, due to poor policies of the past, has seen the region slide into underdevelopment characterized by high poverty levels, persistent drought, poor infrastructure, morbidity and low education levels; if not addressed up front, this combination is likely to lead to increased vulnerability of contracting HIV.
- Vulnerabilities to contracting HIV increase in emergencies owing to: a dangerous interplay of drought, insecurity, migration, displacement, transactional sex and the presence of a major transport corridor.
- A migratory pattern away from the rural areas towards the peri-urban settlements can be observed, especially among women.
- Transactional sex has increased as a result of the drought situation, with the client base shifting towards long-distance truck drivers.
- Condom use is generally low. A BSS report (2004) by IRC indicates that only 58.3 percent of respondents 11-35 years of age had ever used a condom and only 15.4 percent reportedly used a condom the last time they had sexual intercourse. The average number of condoms distributed per person, per month, ranged from 0.5 to 1.0.
- Stigma and discrimination directed at PLHIV are widespread, excluding them further from community support systems that are crucial for survival, especially during periods of drought. PLHIV are considered liabilities so many PLHIV fear disclosing their status lest they lose social capital.
- PLHIV are unable to adequately recover from emergencies, and are increasingly becoming weak and unproductive. Even when general conditions are improving and large parts of the non-PLHIV

population are making modest steps towards recovery, PLHIV are stuck in a continuing “micro-emergency”.

- For those on ART, the emergency provokes abrupt movements of people, which make ART highly inaccessible, thus compromising adherence; so far there are no contingency plans to ensure people adhere to medication under fragile circumstances. Lack of food often leads to people being unable to adhere to their ART; this situation is common in the Turkana region in ‘normal’ circumstances, but intensifies with the escalation of the emergency.
- Faster disease progression among PLHIV who had not yet developed AIDS is commonly reported as a result of the emergency.
- The district- and national-level health implementation system is not responsive to the unique needs of PLHIV in the region. There appears to be a gap among MOH, NACC and partner organizations with respect to the need to consider HIV-related vulnerabilities in the emergency response and develop specific strategies to address them.
- The recurrent emergency in the region stretches limited government and agency resources in dealing with an array of needs; this is coupled with short-term relief efforts which respond at the whim of donor interest.

6.2 Recommendations

- Any future development agenda should formulate and implement long-term policies to address food insecurity, conflict, poverty levels and infrastructure development. These policies should take into account the region’s uniqueness and foster self-reliance.
- Humanitarian response strategies should include HIV, and national strategies for the HIV response should address the specific circumstances of such (and other) emergency situations.
- To respond to the increased vulnerabilities to new HIV infections, HIV prevention campaigns should be intensified in the region, particularly along the main transport corridor and surrounding area. Sex workers and their clients (especially truck drivers), as well as pastoralists, should be targeted.
- Condoms need to be promoted through diverse and innovative approaches and made more readily available to the rural and urban populations, including pastoralists. One approach could be to distribute them through trained peer educators and include them in emergency kits that organizations hand out, provided this is culturally acceptable.
- Decentralizing HIV and VCT services is a priority in the region, along with the urgent need to promote the importance of these services so that people access them.
- More effective food targeting criteria for PLHIV are needed at health facilities and during general food distribution, in order to ensure that their needs are adequately addressed during emergency responses as well as during recovery periods.
- Improved monitoring systems need to be put in place to increase reliability of data on HIV.
- It is essential that stigmatization be adequately addressed. This can be achieved through intensified community sensitization activities. Using *barazas* (local administrative meetings), involving local leaders, setting up peer education programmes and working with active PLHIV support groups are important means to demystify HIV and increase knowledge.
- Stronger livelihood support mechanisms should be developed. This can be done by offering complementary livelihood activities and microfinance initiatives for pastoralists and other vulnerable groups.
- Further research and advocacy work should be encouraged around HIV in emergencies, especially in reference to pastoralists, gender-based violence and coping strategies. This has the potential to inform decisions around relevant and targeted HIV prevention and service packages among these underserved communities.

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Annex 1

People interviewed

Name	Organization /Agency	Designation
Alfred Ikeny Emanimani	Constituency AIDS Coordination Committee-Central Turkana (CACC-Central)	Coordinator
Alex Kuria	Samaritans Purse	Kenya Country Director
Alice Natecho	NACC	Communications Officer-GLIA Focal Point
Girmay Haile	UNAIDS	Monitoring and Evaluation Advisor
Ikeny Kapua	AIC Health Centre (Lokichogio)	Medical officer in-charge
Jackton Lukautom	PLHIV Group Coordinator	Volunteer
John Ekitela	Ministry of Agriculture	District Agriculture Officer
Jeanine Cooper	OCHA	Head OCHA Kenya
Joseph Keter	Constituency AIDS coordination committees North Turkana	Secretary
Linda Beyer	UNICEF	Project Officer
Moses Mukhwana	World Vision, Area Development Programme (ADP)	HIV/AIDS Coordinator
Mr. John Davies	World Initiative for Sustainable Pastoralism	Global Coordinator
Dorothy M.Anjuri	Kenya red Cross	HIV/AIDS Programme Officer
Sammy Ekai	Turkana Development Organization (TUPADO)	Executive Officer
Dr Marleen De Tavernier	Merlin	Project Medical Coordinator
Sister Margaret	Catholic Church, Diocese of Lodwar	Coordinator of Diocese Health Unit
Yakish Eyapan	Ministry of Health, District Hospital - Lodwar	District AIDS Coordination Officer (DASCO)
Alfred Ikeny Emanimani	Constituency AIDS Coordination Committee-Central Turkana (CACC-Central)	Coordinator
Sara Karimbhoy	Merlin	Northern Kenya Programme Coordinator
Jane Kamau	Oxfam	
Francisca Asmit	ATAA "Light" Women Group	Chairperson
Shadrack Oiye	Samaritans Purse	Program Manager
Kephas	IRC	Field Coordinator
John Ekitela	Ministry of Agriculture	District Agriculture Officer
John Maritim	District Development Officer	D.D.O
Joseph Keter	Constituency AIDS coordination committees North Turkana	Secretary
Lucas Edetta	District Public Health Office	Deputy District Public Health Officer
Ruth Kuyah	Turkana Outreach	Chairperson
Niva Lopetet	Youth to Youth Initiative	Chairperson

Rebecca Lomonya	Oxfam	
Sammy Ekai	Turkana Development Organization (TUPADO)	Executive Officer
Sister Margaret	Catholic Church, Diocese of Lodwar	Coordinator of Diocese Health Unit

NB. In addition, in-depth interviews were conducted with seven PLHIV, three pastoralists, three household members of PLHIV, two sex workers and three community elders. One focus group discussion was held with sex workers and three with PLHIV groups.

Annex 2

Fieldwork Guidance

Background information

The countries selected for the case studies were chosen based on a number of criteria, including the kind of emergency they are facing or have faced, the HIV prevalence rate and the geographical location. The following summarizes the preferred focus and sites in each country:

- Mozambique – quick-onset natural disaster in 1 site (Caia), floods preceded by ongoing drought in another (Gaza or Inhambane)
- Kenya – slow-onset natural disaster, drought in the North
- Haiti – quick-onset natural disaster, hurricanes and history of conflict
- CAR – conflict emergency, in the North
- Sri Lanka – quick-onset natural disaster; conflict may overlap but because of another assessment to be carried out by UNHCR on IDPs this will not be the focus

Interviews with organizations involved in the emergency response and people affected by the emergency

The following are some guiding questions to ask both organizations involved in the emergency response and people affected by the emergency. The questions are in some kind of sequence but clearly, if the interviewee wants to talk about something lower down in the list first this is fine; similarly, if the respondent wants to talk about something that is not on this list this is also fine. Generally, rules for running in-depth interviews (IDIs) apply. This is merely a guide to the issues we would like covered, but the conversation should be led as much as possible by the respondent.

IDIs with NGOs/INGOs/government working on HIV/AIDS programmes

- What projects/programmes/services do they run generally for HIV/AIDS? Where do they run the programmes? Who are their target groups?
- What did they do/how did they respond during the emergency, immediately after and some time after the emergency?
- To what extent and in what way did the emergency-situation necessitate a different HIV/AIDS response compared to non-emergency HIV/AIDS interventions?
- How did they adapt their programmes? Did they change their focus? Where they unable to do what they were doing before? Did they go back to their previous projects/programmes? What informed their decisions of what to do? Were they able to prepare beforehand?
- Did they have to change their target groups?
- How were different groups of people differentially affected by the emergency? These could include men, women, children, the elderly, people with specific livelihood categories (e.g. sex workers, truck drivers, fishermen, etc.)
- What specific vulnerabilities have resulted from the emergency for OVC?
- Did displacement occur? What kind of displacement (internal, across borders, large-scale)? What was the impact of this on services, livelihoods, areas where people were displaced, etc.?
- Has there been an economic migration as a result of the emergency? Has there been rural–urban migration as a result of the emergency? If so, how did this impact on HIV-related vulnerabilities and services?
- Have new groups of people particularly vulnerable to acquiring HIV infection emerged as a result of the emergency?
- If doing awareness/educational programmes, how were those affected?
- Have existing health services been overburdened by the emergency, and if so, have HIV and AIDS related services suffered as a result?

- If providing ART, how was their supply of drugs affected? What happened to people on ART? How was their adherence affected? Have they gone back to normal since, and if so what helped them?
- If providing prevention services (condoms, STI treatment, etc.) how was that affected? What did they do to adapt their services?
- How was HIV testing and counselling affected? If disrupted, when did it start up again?
- How was Home Based Care affected?
- How has stigma and discrimination towards HIV-positive people been affected by the emergency response and vice versa?

IDIs with NGOs/INGOs/government working on emergency response

- What did the emergency response consist of? When did it start, how long did it last, who was involved?
- What was the priority focus during the emergency response?
- Did displacement occur? What kind of displacement (internal, across borders, large-scale)? What was the impact of this on services, livelihoods, areas where people were displaced, etc.?
- How was HIV integrated/mainstreamed into the emergency response (prevention, ART, condoms, HIV testing, HBC, etc.)?
- Did responses in other sectors (food aid, shelter, NFIs, etc) take HIV/AIDS into account in any way? Examples might be targeting criteria which included HIV/AIDS proxies (chronically ill), adaptations to food rations, excusing people from public works due to weakness from illness, food security interventions that claim to have HIV/AIDS-related impacts (e.g. home gardens).
- Which people were targeted during the emergency response? Did they include populations most at risk of contracting HIV, which will vary according to the emergency and setting but could include sex workers, IDUs, etc.?
- How were different groups of people differentially affected by the emergency? These could include men, women, children, the elderly, people with specific livelihood categories (e.g. sex workers, truck drivers, fishermen)
- What specific vulnerabilities have resulted from the emergency for OVC?
- How were PLHIV dealt with during the emergency response?
- Did new vulnerabilities emerge as a result of the emergency (e.g. being exposed to humanitarian workers, truck drivers delivering humanitarian assistance)?

IDIs with PLHIV (also on ART) affected by the emergency:

- How long have you been living with HIV?
- (if on ART) How long have you been on ART?
- What are you doing now in terms of a livelihood?
- How were you affected by the emergency? In terms of livelihoods, health, safety, etc. How did you cope/your survival strategies? What were you doing before the emergency? Has your livelihood/standard of living gone back to how it was previously? How as it changed?
- How did you cope/your survival strategies?
- How was your family, children, spouse, etc. affected by the emergency?
- How were different groups of people affected by the emergency?
- What health care were you receiving/accessing prior to the emergency? How has this changed/ been affected by the emergency? What strategies are you now using?
- (if on ART) How was your access to ART affected by the emergency? What strategies did you use to overcome the difficulties?
- What was your main source of food before the emergency? Were you receiving food/nutritional support before the emergency? Were you able to access enough food for you and your family during the emergency? Do you have particular nutritional needs due to HIV/AIDS and could you meet these during the emergency?
- What other basic services were you accessing/receiving before the emergency (education, sanitation, food supplementation, etc.)? How have they been affected by the emergency?

- Has being HIV-positive affected the way you have been dealt with by organizations involved in the emergency response?
- Did you experience stigma and discrimination before the emergency? Has this been affected by the emergency?

IDIs with members of households affected by HIV/carers of PLHIV or others who could give information on HIV vulnerabilities result from the emergency (OVC, elderly, community leaders, etc.) – would have to be tailored for the specific person, the following are some broad questions:

- How were you/your community affected by the emergency in terms of livelihoods, health, safety, etc.? How did you cope/your survival strategies? What were you doing before the emergency? Has your livelihood/standard of living gone back to how it was previously? How has it changed?
- How were the PLHIV you are living with/caring for/in the community affected by the emergency?
- Did the PLHIV you are living with/caring for/in the community experience stigma and discrimination before the emergency? Has this been affected by the emergency?
- What health care was the PLHIV you were living with/caring for/in the community receiving/accessing before the emergency? How has this changed/been affected by the emergency? What strategies are they now using?
- What specific vulnerabilities have resulted from the emergency for OVC?
- What other basic services were they accessing/receiving prior to the emergency? Education, sanitation, food supplementation, etc. How has this been affected by the emergency?

IDIs/FGDs with sex workers affected by the emergency:

- Where do you carry out your sex work? For how long have you been doing it? Who are your clients? Is this your main form of livelihood?
- Are you aware of HIV/AIDS? What do you know about HIV/AIDS prevention, transmission, treatment?
- How were you affected by the emergency? Did your clients change? How was your safety affected? How did you cope/your survival strategies? Have your livelihood strategies changed as a result of the emergency?
- Were you using condoms with your clients before the emergency? Were you using condoms during? After?
- What health care were you receiving/accessing prior to the emergency? How has this changed/been affected by the emergency? What strategies are you now using?
- What other basic services were you accessing/receiving prior to the emergency? Education, sanitation, food supplementation, etc. How has this been affected by the emergency?
- How were different groups of people affected by the emergency?
- Who do you think has become vulnerable as a result of the emergency? Why? Vulnerable to what? Who is the most vulnerable? (for FGDs)