

The impact of emergencies on people living with and affected by HIV and AIDS

Case study Mozambique

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Siân Long and Cerejeira dos Santos Pedro Tinga

* 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

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

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
CBO	Community-based organisation
CNCS	Conselho Nacional de Combate ao HIV/SIDA – National Council to Combat HIV/AIDS
FDC	Fundação de Desenvolvimento Comunitária (Community Development Fund)
HBC	Home-based care
HIV	Human Immunodeficiency Virus
INGC	Instituto Nacional de Gestão de Calamidades (National Institute for Disaster Management)
MISAU	Ministério de Saúde (Ministry of Health)
MMAS	Ministério de Mulher e Acção Social (Women and Social Action Ministry)
MONASO	Mozambican Network of AIDS Service Organisations
NGO	Non governmental organisation
OVC	Orphans and vulnerable children
PARPA II	Plano de Acção para a Redução da Pobreza Absoluta (Action Plan for the Reduction of Absolute Poverty)
PMTCT	Prevention of Mother to Child Transmission
RENSIDA	Rede Nacional das Pessoas Vivendo com VIH/SIDA (National Network of People living with HIV and AIDS)
SETSAN	Secretariado Técnico de Segurança Alimentar e Nutrição (Technical Secretariat on Food Security and Nutrition)
SGBV	Sexual and gender-based violence
UNAIDS	Joint UN Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nation's Children's Fund
VCT	Voluntary Counselling and Testing
WFP	World Food Programme

Executive summary

This case study forms part of a larger study, undertaken by the Overseas Development Institute (ODI) in partnership with the World Food Programme (WFP) and UNAIDS. The overall objective is to gain a better understanding of the various emergency settings and their implications for HIV and AIDS. Five countries have been chosen for field work, representing different levels of HIV prevalence and emergency types. Mozambique was selected because of its high HIV prevalence and a number of slow-onset and rapid onset emergencies that occur regularly – drought, flood and cyclone.

The study comprised a desk review and interviews with key informants, both at national and regional level with representatives from humanitarian and HIV organisations, and at field level in two areas. One was the frequently drought-affected district of Guijá and the other was Caia and surrounding districts, affected by the floods in early 2007.

Country context

Mozambique has faced grinding poverty, conflict and more than the usual number of natural disasters. Despite impressive economic gains achieved since the signing of the peace accord in 1992, over half of the population live in absolute poverty. The ongoing challenges of natural disasters play an important role both as a cause and a consequence of poverty. Floods and cyclones destroy the emerging infrastructure and communication systems and devastate household and commercial economic assets. Already weak social and economic infrastructure makes it harder for people already living in poverty to protect themselves from shocks, such as the cyclical droughts that affect parts of Mozambique.

Mozambique has one of the highest and fastest growing HIV epidemics in the world. Adult prevalence rate is 16% according to the latest antenatal prevalence data, but this hides huge disparities within the country. There is still very limited HIV data available below provincial level. Gender inequities are particularly acute in young women, with three HIV-positive young women to every HIV-positive young man. There is a need for more prevention programming – levels of knowledge about HIV remain low and access to prevention services such as VCT or STI treatment are also low. Poverty and already high levels of death and disease make it hard for people to take preventive steps. It is estimated that about 1.3 million adults and children were living with HIV in 2003.

There has been rapid rollout of treatment in the public health sector in the past two years, with ART and associated tests provided free once people have been able to access HIV testing and reached the nearest treatment site. Roll out has so far extended to district centres although there are plans for further decentralisation. ART access is increasing at a rate of about 6,000 new patients per month. However, access in rural areas is still extremely limited and there is often a lack of VCT services to go hand-in-hand with the ART roll-out.

Mozambique is prone to a wide range of natural disasters: cyclones, drought and flooding. The country is reliant on rain-fed subsistence agriculture as a mainstay for livelihoods, which means that natural disasters have an immediate and profound impact both for those directly affected but also for the economy as a whole. Overall, 48.2% of the population is prone to drought, flooding or both. From 1990 – 2007 an estimated 9,900,000 people were affected by either floods, drought or cyclones and an average of 500,000 people are likely to be affected by rapid onset flooding and cyclones and/or slow onset drought each year for at least the next 5-15 years.

Programmatic responses

The February 2007 flood responses were well prepared and seemingly well coordinated. Simulation exercises coordinated by INGC at the end of 2006, and a functioning early warning system meant that as the waters slowly rose, people were able to relocate with sufficient warning. 163,000 people were accommodated in 40 accommodation centres and the remainder arranged their own accommodation with family or friends living in non-flood affected areas. Many people were able to move most of their portable assets. Those in the accommodation centres received food and non-food items. Those with fields in the low land but who were living on high ground did not receive food or non-food assistance. Assistance included shelter, water and sanitation provision in camps, agricultural inputs for those who had lost the crop (the flood occurred at harvest time) and protection interventions, for example education interventions in the camp. The majority of health care in the emergency was provided by existing local health facilities and many of the accommodation centres were set up near local health facilities. There were no disease epidemics specifically attributable to displacement, such as cholera, nor significantly increased morbidity or mortality, although already high levels of malaria and diarrhoeal disease apparently did not decrease in the accommodation centres either (WHO, 2007).

The main government focus for chronic drought areas is on longer-term improvements in the agricultural sector coupled with agricultural input fairs. However, there are frequent general food distributions, usually with food provided by WFP and coordinated by district administration. The numbers receiving general food distribution during the hungry months is still large. Much of the drought affected area was also the epicentre of the 2000/1 floods when at least 700 people were killed and there was immense devastation.

There has been a general acceptance that HIV has been insufficiently integrated into the flood response. The main problems are considered to be: little coordination between humanitarian agencies and HIV-related agencies or even between humanitarian and development/HIV staff in the same organisation; limited condom provision in the first few days of displacement; limited or late involvement of HIV-specific agencies; lack of local HIV data and also lack of involvement of local HIV bodies such as MONASO or the District AIDS Nucleus; limited gendered analysis of the emergency or response needs. Training was provided on child protection and sexual exploitation, condoms were distributed and a post-recovery fund was provided by the National AIDS Council (CNCS) in the four affected provinces.

In the South, the ongoing chronic poverty is exacerbated by acute food shortages on a regular basis. Interventions for longer-term economic improvements exist alongside vulnerable group feeding and sporadic humanitarian food aid. The extent to which HIV is effectively integrated into such responses varies and is discussed below.

Effects of the emergency

On vulnerable groups: The emergencies occurred in the context of already high levels of absolute poverty and HIV. What would have been a small event becomes an 'emergency' because of the scale of pre-existing vulnerabilities. With very little HIV data available, and poor record keeping in areas such as STI treatment, there is limited evidence of increase in HIV transmission. However, there was overwhelming evidence, reported by both community members and local service providers, that there was an increase in sex because of both flood and drought, with a significant amount likely to be unprotected, often in exchange for material benefit. This included young women who seemed to be having more unprotected sex, in the case of the flood largely because of the greater opportunity in an accommodation centre with more people around, greater opportunities for mobility and fewer social restrictions. In the case of the drought, reportedly because of a lack of alternative sources of income for younger women. Transactional sex also reportedly increased in the flood-affected site between beneficiaries of humanitarian aid (the displaced) and non-beneficiaries (the host community, many of whom had also lost their crops).

Some of the livelihoods interventions targeted at specific groups as a poverty reduction measure in Gaza Province seemed to increase women's vulnerability to HIV infection by supporting them to become mobile traders but without a proactive HIV prevention component.

Young men were rarely included in interventions supporting the most vulnerable in drought-affected areas because they are not there, frequently migrating to South Africa. This lack of intervention also seems, by default, to be increasing their HIV vulnerability, and those of their sexual partners.

There was no evidence of a noticeable increase in sexual exploitation as a direct result of the emergency, for example of sex in exchange for humanitarian aid. However, sexual and gender-based violence (SGBV) was noticed in accommodation centres after displacement from the floods, much of it reported to be linked to alcohol consumption. It is unclear whether SGBV increased or whether it was simply noticed more because of the closer living arrangements.

There was inconclusive evidence about whether already vulnerable groups were disproportionately affected because of the emergency itself. In general, it was felt that households who were not able to flee the floods or build houses in accommodation centres were supported by their neighbours and were not excluded from distribution of humanitarian assistance.

There was consistent feedback from informants in both flood-affected and drought-affected areas that children in particular took on more piece work (*ganho ganho*) to support household income after the flood and during droughts. This was also the case for people living with HIV.

Already extremely food-insecure households, including many of those that are HIV-affected, are becoming increasingly impoverished. The longer-term livelihoods interventions in drought-affected areas are either dependent on available water sources or based on small-scale interventions that are not meeting household needs. It was too early to assess whether post-recovery operations in the flood-affected areas were going to meet the livelihoods needs of those who are too labour-poor to benefit from the agricultural focus of the response.

An increased number of sex workers arrived to the flood affected areas during the emergency but have since returned to their former towns. Those sex workers who participated in the study felt that there had been sufficient access to condoms during the emergency, with access to free condoms being better than either before or after.

Impact on people living with HIV

The main ways in which a rapid or slow onset emergency could increase the vulnerability of people living with HIV include: disruption in supply of treatment and care both for antiretroviral drugs and care and support of opportunistic infections including TB; reduced access to food, clean water and sanitation thus increasing exposure to infections; reduced access to condoms increasing the chances of unsafe sex for both the HIV-positive person and sexual partners; increase in stigmatisation, marginalisation or discrimination against people living with HIV. The situations in flood-affected and slow-onset areas were found to be quite different.

The most commonly cited impact of drought on people living with HIV, during this study, was reduced adherence to ART and increased deaths of HIV-positive people due to lack of food. This was referred to as the number one problem by every community-level informant in Guijá. There are, however, many possible reasons for defaulting on treatment in addition to lack of food to eat. Other reasons for failed adherence need further exploration.

In flood-affected areas, the situation was very different. There was limited or no disruption of care or support because there was already an extremely low level of service provision to the displaced communities, with little or no access to ART or to home based care services. Those who were on

treatment already were already living near the district centre and were not displaced, primarily because of the limited access to VCT and ART in the flood-prone areas. The few displaced people who were on ART were apparently able to continue treatment because of the efforts by health workers and activists who walked around the camps looking for them. However, it was observed by several informants that if there had been significant numbers registered on the ART programme, or receiving TB treatment, it would have been harder due to a lack of documentation that could be used for tracing.

There was no report of HIV transmission risks during blood transfusion or because of lack of infection control measures, although data on this was not gathered. Because displacement happened generally in an organised fashion and there was no noticeable increase in diseases requiring blood transfusion or in trauma requiring surgery, it is unlikely that there was an increased need for blood transfusion. Condoms were reported as not being available during the immediate displacement. This gap was remedied in the medium-term with both the National AIDS Control Programme and a number of humanitarian agencies providing free condom distribution through health posts and general distribution.

Health workers in the health centres reported that malaria, HIV-related illnesses and diarrhoeal diseases were the main causes of death. However, the levels of malaria morbidity and mortality were no greater than normal (WHO, 2007). The fact that morbidity and mortality rates were reported as having no significant change is an indication of how serious malaria already is and how limited are the existing health facilities before the emergency. Although it would be hard to provide insecticide-treated bed nets to HIV-positive people at present, given the very low numbers of people who know their status, the high levels of malaria suggest a severe impact on people living with HIV.

People living with HIV in the flood-affected areas did report difficulties in returning to their pre-flood farming areas. The need to replant crops and the distance to travel was a problem and they were relying on *ganho ganho* (piece work) to a far greater extent than before the floods.

In the drought-affected areas, one livelihood option that people were taking up was migration. Many people on ART appeared to be going to South Africa, almost all with no referral letter to continue treatment there. The assumption is that these people were feeling well enough to work again. This is not strictly related to the emergency. However, there is a connection in that this failure to adhere did not seem to be addressed sufficiently by some of those providing care and support because of an assumption that lack of food must be the cause.

Despite limited disruption of existing services (education was disrupted during the floods but seemed to be addressed quite rapidly in accommodation centres), there was limited focus on HIV-related services during the displacement. This was a lost opportunity for increasing access to and use of HIV care and support. Despite immediate provision of services such as water and sanitation immediately after displacement, longer-term provision was reported to be a problem.

Key findings

The most striking finding related to increased risk of HIV transmission is the substantial increase in transactional sex during and after the emergencies. This was evident in both flood-affected and drought-affected areas. In the case of population displacement in the flood-affected area, there was reported transactional sex between displaced and host community members. There was a significant level of transactional sex between local girls and women and men who were mobile – mainly truckers and construction workers. This transactional sex was reported in both sites at all times of the year, and before the emergency in the case of Caia. However, it was reported that numbers of girls and women engaging in sex at transport routes increased after the emergency or during the hungry periods in the chronic drought context. There were also reports of an increase in consensual sex, particularly amongst younger women, in accommodation centres. The changes

that were reported seemed to be a greater number of sexual partners and sexual relationships that were not recognised within existing social mores, leading to a greater number of unwanted pregnancies that were not acknowledged and supported by the alleged fathers and their families.

In the flood-affected areas, the main emphasis in the emergency response was provision of prevention information during the immediate displacement through use of awareness campaigns and condom distribution. However, there was limited information prior to the emergency that could inform an effective prevention campaign (for example, local KAP studies or cultural or gendered analysis of the epidemic). There were higher levels of HIV awareness in the drought-affected areas and an existing cadre of community volunteers who would be able to conduct mass prevention awareness sessions if needed in another rapid onset flood. Community members and local NGOs, however, were not aware of any emergency preparedness planning activities for displacement.

HIV prevention needs are insufficiently integrated into emergency preparedness planning and response. Several livelihoods interventions – designed as a response to the chronic food insecurity in the drought-affected area - appear to unintentionally be increasing women's vulnerability to HIV infection. In other cases, some groups of people who appear to have an elevated risk of HIV infection during times of heightened food insecurity. In particular, young men in the traditional migration areas that are affected by chronic drought are migrating to South Africa in a less organised way which is likely to be exposing them to HIV.

In both flood and drought areas, there was a reportedly large increase in piece work (*ganho ganho*) by children after the emergency. Much of this appeared to be exploitative and likely to lead to physical violence, increased risk of HIV infection and longer-term reduced life options because of school drop out.

In the flood affected site, it was relatively easy for people to continue ARV treatment. The few people who were already receiving treatment continued to do so after the floods. However, the general feeling from people living with HIV and local service providers is that this is largely because there were few displaced people already receiving treatment. There were concerns that this would be more difficult as numbers of people registered for treatment rise, because record keeping and systems for ensuring continuity of treatment were reported to be weak.

Malaria prevention was not seen as an important HIV-specific finding according to interviews conducted during this study. The very high level of malaria in the area during the emergency presumably affected people living with HIV, including pregnant women. No data was found to indicate whether the emergency made people living with HIV more vulnerable to malaria or more or less able to access early prevention and treatment. The absence of data on malaria and HIV itself indicates the lack of consideration of HIV-specific factors in the emergency response.

In drought-affected areas, there is a need to explore in more detail the high levels of treatment drop out in order to find the most appropriate responses, especially to identify those which are directly attributable to food insecurity because of general drought and those which may have another cause, such as the lack of money for transport (exacerbated by poor harvests), incomplete adherence counselling or a return to (migratory) work by a person whose health is improving.

Cyclical and regular emergencies seem to be inhibiting a sufficient focus on non-emergency HIV responses necessary to address long-term absolute poverty.

A number of specific recommendations are made in section 6.2 relating to the key findings. A brief summary follows:

Prevention of HIV

- Technical assistance could assist in introducing gender-related analysis and emergency preparedness so that there is a core group of activists able to identify and address emergency-specific social and economic changes that lead to HIV risk.
- It is essential to make efforts to develop prevention activities before (and after) floods, especially in the more remote areas. If prevention activists are involved in rapid-onset emergency contingency planning, they will be able to identify 'hot spots' or negative trends in sexual behaviour during the emergency, for example in emergency centres for displaced people.
- In drought-prone areas, community groups can play a role in monitoring any increase in transactional sex that appears to be linked to growing food insecurity and in ensuring that women and girls involved in transactional sex can access prevention support (such as condoms), but also that they may have other means of earning a livelihood. SGBV forms a core part of this and requires a longer-term community-based focus in which older and younger men and women are able to discuss issues of gender violence and vulnerability.
- Condoms should be primarily made available through these groups and health and other emergency facilities. Such linkages are best made in ongoing emergency preparation and ensuring that 'non-emergency' HIV representatives form a core part of emergency preparedness and contingency planning in areas prone to both rapid onset and slow onset emergencies.
- It would be interesting to explore the migration experiences of young men and in particular see whether there is a link with ongoing poverty.
- With greater engagement of local HIV prevention, care and support groups (or a coordinating body such as MONASO) in emergency preparedness planning, it should be easier to ensure that these services are accessible to those living with HIV or vulnerable to HIV.

Impact of emergency on people living with HIV and affected groups

- It would be useful to understand the scale and impact of *ganho ganho* being done by boys and girls after an emergency. In particular, it would be useful to understand more about what the risks might be in relation to school drop out, sexual or physical abuse, longer-term household impact and the type of child undertaking such work.
- It would be useful to understand more what the impact of a rapid-onset emergency is on the livelihood options of people living with HIV.

Impact on service provision

- In settings where people are displaced during an emergency, there is an opportunity to improve access to counselling, testing and – where necessary – treatment, care and support of people living with HIV.
- Future contingency planning should identify home-based care interventions in emergency preparedness. Their role during displacement would be to ensure that regular supplies continue, that facilities such as water and sanitation are provided and do not adversely affect chronically sick patients.
- Malaria prevention is a priority for people living with HIV. Emergency interventions can facilitate access to malaria prevention information, insecticide treated nets and malaria care for all, and in particular to people living with HIV, especially pregnant women.
- Treatment dropout should be aggressively pursued to identify individual causes in addition to lack of food, in settings where food distribution has happened over a period of years.

Impact on livelihoods

- It will be important to review the CNCS impact mitigation funded project evaluations and see whether the projects have analysed particular livelihoods needs (labour constraints, need to be based near a treatment centre, impact of earlier discrimination such as loss of land or assets after being widowed) and integrated these into the programmes.
- There are several recent studies of mainstreaming HIV into livelihoods programmes across Southern Africa. It will be useful to apply and adapt appropriate lessons into the immediate and longer-term livelihoods recovery programmes.

Conclusions

The study found that both rapid onset and slow onset natural disasters heighten the risk of HIV transmission for women, especially young women. This risk, however, can be hidden and is not necessarily recognised as sexual and gender-based violence by the communities where it is happening. The 'hidden vulnerability' of women and girls who face a relatively minor displacement has significant implications for their HIV risk.

The floods did not seem to have a strong and long-lasting negative impact on people living with HIV because it appears that the localised displacement, and the fact that floods occurred in places where there was little health infrastructure, did not disrupt treatment and care. This may be more severe when a sizeable number of people are on treatment. As long as emergency responses such as malaria control and water and sanitation are provided, it appears that people living with HIV were not adversely affected. Stigma was not seen to be a factor that would decrease access to health and other care, given the high prevalence rates across the country.

In contrast, slow-onset emergencies such as drought had a significant impact on the ability of people living with HIV to access and adhere to anti-retroviral therapy. However, the blurred line between chronic poverty and an 'acute phase of a chronic problem' makes it more difficult to ascribe particular actions to the emergency. The study indicates that HIV-affected households and individuals seem to find it harder to cope with their immediate needs during a prolonged crisis situation, as compared to the non-HIV affected population, and are less likely to recover from it. However, this needs further exploration.

Households already affected by HIV – in particular, elderly headed households and orphans – experienced greater levels of loss during the rapid onset emergency and seemed less able to return to their pre-disaster livelihoods. This was less obviously the case in the slow-onset context but is likely to be the same. The general conclusion is that already HIV-affected households struggle more than their non-HIV affected neighbours, to have their immediate needs met and change their coping mechanisms in a way that both decreases their livelihood options in the medium-term and, possibly, increases their longer-term HIV vulnerability also.

Sumário Executivo

Introdução

Este estudo de caso faz parte de um estudo mais alargado, levado a cabo pelo Overseas Development Institute (ODI) em parceria com o Programa Mundial de Alimentação (PMA) e a UNAIDS. O objectivo geral é de obter uma melhor compreensão sobre os vários cenários de emergência e as suas implicações para HIV e SIDA. Foram seleccionados cinco países para a realização do trabalho no terreno, representando diferentes níveis de prevalência do HIV e tipos de emergência. Moçambique foi seleccionado devido à sua alta taxa de prevalência do HIV e várias emergências repentinas e rápidas que ocorrem regularmente no país – seca, cheias e ciclones.

O estudo compreende uma revisão da documentação e entrevistas com informantes chave, a nível nacional assim como a nível regional, com representantes das organizações humanitárias e organizações ligadas às acções contra o HIV, e ao nível do terreno em dois locais. Um desses locais foi o Distrito de Guijá que é frequentemente afectado pela seca e o outro foi o Distrito de Caia e os distritos circunvizinhos, que foram afectados pelas cheias nos princípios de 2007.

Contexto do País

Moçambique enfrentou uma pobreza acentuada, conflitos e vários desastres naturais em proporções não habituais. Apesar dos avanços económicos impressionantes alcançados desde a assinatura do Acordo Geral da Paz em 1992, mais de metade da população vive em situação de pobreza absoluta. Os actuais desafios relacionados com os desastres naturais constituem um factor crítico como uma causa, assim como uma consequência da pobreza. As cheias e os ciclones destroem as infra-estruturas emergentes e os sistemas de comunicação e afectam os agregados familiares e os bens económicos comerciais. As infra-estruturas sociais e económicas já debilitadas fazem com que seja mais difícil para as pessoas que já vivem em situação de pobreza se protegerem contra os desastres, tais como as secas cíclicas que afectam algumas zonas de Moçambique.

Moçambique possui um dos mais altos e mais crescentes índices da epidemia do HIV no mundo. A taxa de prevalência nos adultos é de 16% de acordo com os últimos dados de prevalência pré-natal, mas isto oculta as grandes discrepâncias dentro do país. Ainda há dados bastante limitados sobre HIV disponíveis a nível provincial. As desigualdades do género são particularmente acentuadas nas mulheres jovens, com uma proporção de três mulheres jovens portadoras do HIV para todos os jovens do sexo masculino portadores do HIV. Há necessidade de mais programas de prevenção – os níveis de conhecimentos sobre o HIV permanecem baixos e o acesso aos serviços de prevenção tais como os GATV ou tratamento de DTSs também são baixos. A pobreza e as já altas taxas de mortalidade e de doenças fazem com que seja difícil para as pessoas tomarem passos preventivos. Estima-se que cerca de 1.3 milhões de adultos e crianças viviam com HIV em 2003.

Registou-se um incremento rápido do tratamento no sector de saúde pública nos últimos dois anos, com os ART e os testes associados disponibilizados gratuitamente, assim que as pessoas tiverem acesso ao teste de HIV e quando tiverem alcançado o local mais próximo para o tratamento. Até aqui, esse aumento expandiu-se até às sedes distritais embora haja planos para uma maior descentralização. O acesso aos ART está a aumentar a um ritmo de cerca de 6,000 novos doentes por mês. Contudo, o acesso nas zonas rurais ainda é extremamente limitado e geralmente há falta de serviços de GATV que estejam em conformidade com o aumento do tratamento através de ART.

Moçambique é propenso a vários desastres naturais: ciclones, seca e cheias. O país depende da agricultura de subsistência dependente da água da chuva como um dos principais meios de vida, o que significa que os desastres naturais têm um impacto imediato e profundo tanto para os que são directamente afectados assim como para a economia no seu todo. De uma forma geral, 48.2% da população é propensa à seca, cheias ou a ambos. De 1990 – 2007, estimava-se que 9,900,000 pessoas foram afectadas pelas cheias, seca ou ciclones e uma média de 500,000 pessoas poderão ser afectadas pelas cheias e ciclones (desastres que ocorrem repentinamente) e/ou um desastre que ocorre lentamente (seca) em cada ano, durante pelo menos os próximos 5 a 15 anos.

Respostas Programáticas

As actividades de respostas às cheias ocorridas em Fevereiro de 2007 foram bem planificadas e bem coordenadas. Os exercícios de simulação coordenados pelo INGC no final de 2006, e um sistema de aviso prévio funcional significaram que à medida em que o nível da água aumentava lentamente, as pessoas foram capazes de abandonar as zonas de risco tendo em conta os avisos que eram emitidos. 163,000 pessoas foram abrigadas em 40 centros de acomodação e os restantes conseguiram alojar-se nas casas de familiares ou amigos que vivem em zonas que não foram afectadas pelas cheias. Muitas pessoas foram capazes de retirar a maior parte dos seus bens. Os que foram abrigados nos centros de acomodação receberam apoio em bens alimentares e não alimentares. Os que possuem machambas nas zonas baixas mas que viviam nas zonas altas não receberam assistência em bens alimentares e não alimentares. A assistência incluía abrigo, abastecimento de água e saneamento do meio nos centros de acomodação, insumos agrícolas para os que haviam perdido as suas culturas (as cheias ocorreram durante a época de colheita) e intervenções em termos de protecção, por exemplo na área de educação nos centros. A maior parte dos serviços de cuidados de saúde durante a emergência foram prestados pelas unidades sanitárias locais existentes e muitos dos centros de acomodação foram criados próximo às unidades sanitárias locais. Não houve registo de doenças epidémicas, especificamente relacionadas com a deslocação de pessoas, tais como a cólera, nem um aumento significativo da morbilidade, embora os elevados índices de malária e doenças diarreicas aparentemente não tenham reduzido nos centros de acomodação (WHO, 2007).

O principal enfoque do governo para as zonas afectadas pela seca crónica é na melhoria a um prazo mais longo no sector agrícola conjugado às feiras de insumos agrícolas. Contudo, geralmente tem havido distribuições frequentes de bens alimentares, que são geralmente efectuados pelo PMA e coordenados pelas administrações distritais. O número de pessoas que recebem apoio em bens alimentares durante os meses de fome ainda é bastante elevado. Grande parte das zonas afectadas pela seca foi também o epicentro das cheias de 2000/1, onde pelo menos 700 pessoas morreram e as zonas afectadas foram imensamente devastadas.

Tem havido uma aceitação geral de que o HIV foi insuficientemente integrado nas acções de resposta às cheias. Os principais problemas apontados foram os seguintes: pouca coordenação entre as agências humanitárias e instituições que implementam actividades relacionadas com o HIV ou mesmo entre os actores humanitários e de desenvolvimento ligados ao HIV na mesma organização; distribuição limitada de preservativos nos primeiros dias após a deslocação das pessoas; envolvimento limitado ou tardio das agências especificamente ligadas ao HIV; falta de dados locais sobre o HIV e também a falta de envolvimento das entidades ligadas ao HIV tais como a MONASO ou os Núcleos Distritais de Combate ao SIDA; análise limitada à questão do género nas actividades de emergências ou de resposta. Foi providenciado um treinamento sobre a protecção das crianças e da exploração sexual, foram distribuídos preservativos e foi disponibilizado um fundo de pós-recuperação pelo Conselho Nacional de Combate ao SIDA (CNCS) nas quatro províncias afectadas.

Na zona sul, a pobreza crónica em curso é regularmente exacerbada pela escassez alimentar aguda. As intervenções visam melhorias económicas a um prazo mais longo, conjugadas com a

provisão de alimentos aos grupos vulneráveis e a ajuda alimentar humanitária esporádica. O nível em que o HIV é integrado de forma efectiva em tais acções de resposta varia e é discutido abaixo.

Efeitos da emergência

Sobre os grupos vulneráveis: As emergências ocorreram no contexto dos já elevados níveis de pobreza absoluta e dos índices do HIV. O que seria um pequeno evento torna-se uma ‘emergência’ por causa do grau de vulnerabilidade pré-existente. Com os dados disponíveis bastante limitados sobre o HIV, e a deficiente manutenção de registos em áreas tais como o tratamento de DTS, existe uma evidência limitada do aumento da transmissão do HIV. Contudo, houve uma clara evidência que foi reportada tanto pelos membros da comunidade assim como pelos provedores locais de serviços, de que houve aumento na prática de relações sexuais por causa das cheias e da seca, com uma quantidade significativa provavelmente desprotegida, geralmente em troca de bens materiais. Isto incluiu mulheres jovens que pareciam estar a praticar mais relações sexuais desprotegidas, no caso das cheias principalmente por causa de haver maior oportunidade num centro de acomodação, com mais pessoas à volta, maior oportunidade de mobilidade e poucas restrições sociais. No caso da seca, tal ocorre alegadamente por causa da falta de fontes alternativas de rendimento para as mulheres mais jovens. O sexo transaccional também foi reportado como tendo aumentado nas zonas afectadas pelas cheias no seio dos beneficiários de ajuda humanitária (os deslocados) e os não beneficiários (os membros da comunidade anfitriã, muitos dos quais também haviam perdido as suas culturas).

Algumas intervenções em termos de meios de subsistência com enfoque aos grupos específicos como uma medida de redução da pobreza na Província de Gaza parece que aumentaram o grau de vulnerabilidade das mulheres em relação à infecção pelo HIV, fazendo com que se tornassem vendedoras ambulantes mas sem uma componente pró activa de prevenção do HIV.

Raramente, os homens jovens foram inclusos nas intervenções, apoiando as pessoas mais vulneráveis nas zonas afectadas pela seca porque não estão presentes nessas zonas, frequentemente migrando para a África do Sul. Esta falta de intervenção também parece, por defeito, estar a aumentar a sua vulnerabilidade em relação ao HIV e dos seus parceiros sexuais.

Não houve evidência de aumento da exploração sexual notável como um resultado directo da emergência, por exemplo de sexo em troca de ajuda humanitária. Contudo, a violência sexual e baseada no género (SGBV) foi observada nos centros de acomodação depois da deslocação das zonas de cheias, grande parte das quais reportaram estar relacionadas com o consumo de álcool. Não está claro se a SGBV aumentou ou se foi simplesmente observada mais pelo facto de as pessoas estarem a viver muito próximos uns aos outros.

Houve evidência inconclusiva sobre se os grupos já vulneráveis foram desproporcionalmente afectados por causa da emergência em si. No geral, havia um sentimento de que os agregados familiares que não eram capazes de fugir das cheias ou de construir as suas casas nos centros de acomodação foram apoiados pelos seus vizinhos e não foram excluídos da distribuição de assistência humanitária.

Houve um “feedback” consistente dos informantes tanto nas zonas afectadas pelas cheias assim como nas zonas afectadas pela seca, de que as crianças, particularmente dedicaram-se mais em actividades de ganho - ganho para contribuírem na geração de renda ao nível dos agregados familiares depois das cheias e durante a seca. Este foi também o caso de pessoas vivendo com HIV.

Os agregados familiares já com problemas de insegurança alimentar extrema, incluindo muitos dos que são afectados pelo HIV, estão a tornar-se cada vez mais empobrecidos. As intervenções em termos de meios de vida a longo prazo nas zonas afectadas pela seca são dependentes das fontes de água disponíveis ou baseadas nas intervenções de pequena escala que não satisfazem as necessidades dos agregados familiares. Era demasiadamente cedo avaliar se as operações

pós-recuperação nas zonas afectadas pelas cheias iriam satisfazer as necessidades em termos de meios de vida das pessoas demasiadamente fracas em termos de trabalho para beneficiarem da actividade agrícola em termos de resposta.

Um grande número de trabalhadoras do sexo chegou às zonas afectadas pelas cheias durante o período de emergência, mas desde então, já regressaram às suas zonas de origem. Essas trabalhadoras do sexo que participaram no estudo sentiram que houve pouco acesso aos preservativos durante o período de emergência, com o acesso aos preservativos a ser considerado melhor em relação ao período antes ou depois.

Impacto sobre as pessoas vivendo com HIV

As principais formas em que uma emergência rápida ou lenta poderiam aumentar a vulnerabilidade das pessoas vivendo com HIV incluem: interrupção na prestação de tratamento e nos cuidados com antiretrovirais assim como os cuidados e apoio às infecções oportunistas incluindo a tuberculose; acesso reduzido aos alimentos, à água potável e ao saneamento do meio, aumentando assim a propensão às infecções; acesso reduzido aos preservativos, agravando as oportunidades de sexo não seguro tanto para a pessoa portadora de HIV e os seus parceiros sexuais; aumento da estigmatização, marginalização ou discriminação contra as pessoas vivendo com HIV. Constatou-se que as situações nas zonas afectadas pelas cheias e nas zonas com desastres que ocorrem lentamente eram bastante diferentes.

Em comum, o impacto mais citado da seca sobre as pessoas vivendo com HIV, durante este estudo, foi a reduzida aderência aos ART e o aumento das mortes nas pessoas vivendo com HIV devido à falta de alimentos. Este facto foi considerado como sendo o primeiro problema por todos os informantes comunitários em Guijá. Existem, porém, muitas possíveis razões da falta de tratamento para além da falta de alimentos para o consumo. Outras razões para a fracassada aderência carecem de mais explicação.

Nas zonas afectadas pelas cheias, a situação era bastante diferente. Houve cuidados limitados ou não houve interrupção nos cuidados ou no apoio porque já havia um nível de prestação extremamente baixo desses serviços para as comunidades deslocadas, com pouco ou mesmo sem acessos aos ART ou ainda os cuidados domiciliários. As pessoas que estavam em tratamento já viviam próximo à sede distrital e não eram deslocadas, principalmente por causa do acesso limitado aos GATV e aos ART nas zonas propensas às cheias. As poucas pessoas deslocadas que estavam a receber o tratamento com ART eram aparentemente capazes de continuar a fazer o tratamento por causa dos esforços envidados pelos trabalhadores de saúde e activistas que se deslocavam nos centros de acomodação à sua procura. Contudo, observou-se a partir de vários informantes que se tivesse havido números significativos registados no programa de ART, ou a receber tratamento da tuberculose, teria sido mais difícil devido à falta de documentação que seria usada para o efeito.

Não foram reportados casos de riscos de transmissão do HIV durante a transfusão de sangue ou por causa da falta de medidas de controlo contra a infecção, embora não tenham sido recolhidos dados sobre este facto. Tendo em conta que a deslocação de pessoas geralmente ocorreu de uma forma organizada e não houve aumento notável de doenças que requerem transfusão de sangue ou de trauma que requer uma intervenção cirúrgica, é pouco provável que tenha havido uma necessidade acrescida de transfusão de sangue. Foi reportado que os preservativos não estavam disponíveis imediatamente depois da deslocação das pessoas. Esta lacuna foi remediada a médio prazo com o Programa Nacional de Controlo da SIDA e o número de agências humanitárias a distribuírem gratuitamente preservativos através dos postos de saúde, assim como através das distribuições feitas de forma geral.

Os trabalhadores de saúde nos centros de saúde reportaram que a malária, as doenças relacionadas com o HIV e as doenças diarreicas foram as principais causas da morte. Contudo, os níveis de morbidade em relação à malária e a mortalidade não eram superiores em relação aos normais (OMS, 2007). O facto de as taxas de morbidade e de mortalidade terem sido reportados

como não tendo sofrido uma mudança significativa é uma indicação de quão grave já é a malária e quão limitados são os centros de saúde existentes antes da emergência. Embora seja actualmente difícil distribuir redes mosquiteiras impregnadas às pessoas portadoras do HIV, devido ao número bastante baixo de pessoas que conhecem o seu estado de saúde, as altas taxas de malária sugerem que há um impacto bastante grave sobre a vida das pessoas vivendo com HIV.

As pessoas vivendo com HIV nas zonas afectadas pelas cheias reportaram ter havido dificuldades de regressar às suas zonas agrícolas anteriormente não afectadas pelas cheias. A necessidade de voltar a lançar a semente e a distância para viajar foi um problema e as pessoas dependiam da actividade de ganho - ganho muito antes das cheias.

Nas zonas afectadas pela seca, uma opção de meio de vida que as pessoas tomaram foi a migração. Aparentemente, muitas pessoas em tratamento com ART se deslocavam à África do Sul, quase sem nenhuma carta de referência para continuar com o tratamento no país. A suposição é de que estas pessoas se sentiam suficientemente bem para retomarem o trabalho. Isto não está estritamente relacionado com a emergência. Contudo, existe uma relação uma vez que este fracasso de aderir ao tratamento aparentemente não foi suficientemente abordado por algumas pessoas que prestam cuidados e apoio devido a uma suposição de que a falta de alimentos deve ser a causa.

Apesar da limitada interrupção dos serviços existentes (a educação foi interrompida durante as cheias, mas parece que foi muito bem abordada e de forma rápida nos centros de acomodação), houve um enfoque limitado aos serviços relacionados com o HIV durante o período em que as pessoas se tornaram deslocadas. Esta foi uma oportunidade perdida de aumentar o acesso e de se beneficiarem dos cuidados e apoio relacionados com o HIV. Apesar da provisão imediata de serviços tais como água e saneamento do meio imediatamente depois das pessoas terem perdido as suas casas, foi reportado que a prestação dos serviços a um prazo mais longo constituía um problema.

Principais constatações

A principal constatação relacionada com o risco acrescido de transmissão do HIV é o aumento substancial do sexo transaccional durante e depois das emergências. Este facto foi evidente tanto nas zonas afectadas pelas cheias assim como nas zonas afectadas pela seca. Em caso de deslocação da população nas zonas afectadas pelas cheias, foram reportados casos de sexo transaccional entre os membros da comunidade deslocada e os membros anfitriões. Houve um nível significativo de sexo transaccional entre as raparigas locais e as mulheres e os homens que se deslocavam – principalmente os camionistas e os trabalhadores das obras de construção. Este sexo transaccional foi reportado em ambos os locais durante quase todos os períodos do ano, e antes da emergência tal como o caso de Caia. Contudo, foi reportado que o número de raparigas e mulheres envolvidas no sexo nas rotas de transporte aumentou depois da emergência ou durante os períodos de fome no contexto de seca crónica. Também houve casos de um aumento no sexo consensual, particularmente no seio das mulheres mais novas, nos centros de acomodação. Aparentemente, as mudanças que foram reportadas eram em maior número de parceiros sexuais e relacionamentos sexuais que não eram reconhecidos dentro da organização social existente, levando a uma maior número de gravidezes não desejadas que não foram reconhecidos e apoiados pelos alegados pais e suas famílias.

Nas zonas afectadas pelas cheias, a ênfase principal na resposta à emergência foi a provisão de informação sobre a prevenção durante a deslocação imediata das pessoas, através do uso de campanhas de sensibilização e distribuição de preservativos. Contudo, houve informação antes da emergência que poderia garantir a realização de uma campanha de prevenção eficaz (por exemplo, estudos locais de KAP ou uma análise cultural ou do género sobre a epidemia). Houve maiores níveis de sensibilização sobre o HIV nas zonas afectadas pela seca e uma rede existente

de voluntários da comunidade que seriam capazes de levar a cabo sessões massivas de prevenção em caso de necessidade numa outra situação de cheias ocorrendo repentinamente. Entretanto, os membros da comunidade e as ONGs locais não estavam a par de nenhuma actividade de planificação de acções de preparação para situações de emergência para as pessoas deslocadas.

As necessidades em termos de prevenção do HIV são insuficientemente integradas nas actividades de preparação e resposta à emergência. Várias intervenções em termos de meios de vida – designadas como sendo resposta à insegurança alimentar crónica nas zonas afectadas pela seca – parecem estar intencionalmente a aumentar o nível de vulnerabilidade da mulher em relação à infecção pelo HIV. Noutros casos, alguns grupos de pessoas que pareciam ter um elevado risco de infecção pelo HIV durante o período de insegurança alimentar acentuada. Em particular, os jovens nas zonas de migração tradicional que são afectadas pela seca crónica migram para a África do Sul de forma menos organizada, o que provavelmente está a expô-los ao HIV.

Tanto nas zonas afectadas pelas cheias assim como nas zonas afectadas pela seca, houve casos de um grande aumento do trabalho do tipo *ganho - ganho* pelas crianças depois da emergência. Grande parte disso parecia ser exploratório e provavelmente leva à violência física, risco acrescido de infecção pelo HIV e opções mais longas de vida reduzidas devido à desistência nas escolas.

Nas zonas afectadas pelas cheias, foi relativamente fácil para as pessoas continuar com o tratamento com antiretrovirais. As poucas pessoas que já estavam a receber o tratamento continuaram a fazê-lo depois das cheias. Contudo, o sentimento geral das pessoas vivendo com HIV e os provedores locais de serviços é que isso está, em grande medida, relacionado com o facto de que houve poucas pessoas deslocadas que já estavam a receber o tratamento. Houve preocupações de que tal seria mais difícil uma vez que o número de pessoas registadas para o tratamento aumentou, uma vez que o registo e os sistemas para assegurar a continuidade do tratamento foram considerados fracos.

A prevenção da malária não foi vista como sendo uma constatação importante específica relacionada com o HIV para as entrevistas realizadas durante este estudo. O nível bastante elevado de casos de malária na zona durante o período de emergência era presumivelmente de pessoas afectadas vivendo com HIV, incluindo as mulheres grávidas. Não foi encontrado nenhum dado que indica se a situação de emergência fez com que as pessoas vivendo com HIV fossem mais vulneráveis à malária ou mais ou menos o acesso à prevenção e ao tratamento. A ausência de dados sobre a malária e HIV em si indica a falta de consideração de factores específicos relacionados com HIV na resposta à emergência.

Nas zonas afectadas pela seca, houve necessidade de explorar de forma mais detalhada os altos índices de desistência ao tratamento, com vista a encontrar as respostas mais adequadas, especialmente para identificar as que são directamente atribuídas à insegurança alimentar devido à seca generalizada e as que podem ter uma outra causa, tais como a falta de dinheiro para o transporte (aliado à fraca colheita), aconselhamento sobre a aderência incompleta ou o regresso (migratório) ao trabalho por uma pessoa cujo estado de saúde está a registar melhorias.

As emergências cíclicas e regulares parecem estar a inibir um enfoque suficiente sobre as actividades de resposta ao HIV, não relacionadas com a emergência necessária para abordar a pobreza absoluta a longo prazo.

São avançadas várias recomendações na secção 6.2 relativas às principais constatações. Abaixo, um breve resumo:

Prevenção do HIV

- A assistência técnica poderia contribuir para a introdução de uma análise relacionada com a questão do género e a prontidão aos desastres de modo que haja um grupo fundamental de activistas para identificar e abordar mudanças sociais e económicas especificamente relacionadas com a emergência relativa ao risco de HIV.
- É essencial envidar esforços com vista a desenvolver actividades de prevenção antes (e depois) das cheias, especialmente nas zonas mais recônditas. Se os activistas ligados à prevenção forem envolvidos na preparação dos planos de emergência repentina, eles serão capazes de identificar 'locais críticos' ou tendências negativas no comportamento sexual durante a emergência, por exemplo nos centros de emergência para as pessoas deslocadas.
- Nas zonas afectadas pela seca, os grupos comunitários podem desempenhar um papel na monitoria de qualquer aumento do sexo transaccional que parece estar relacionado com a crescente insegurança alimentar e assegurar que as mulheres e as raparigas envolvidas no sexo transaccional possam ter acesso ao apoio em termos de prevenção (tal como preservativos), mas também que possam ter meios de obtenção de um meio de subsistência. A SGBV constitui uma parte fundamental disto e requer um enfoque baseado na comunidade a longo prazo em que os homens mais velhos e os mais jovens e as mulheres sejam capazes de discutir questões relacionadas com a violência do género e vulnerabilidade.
- Os preservativos devem ser disponibilizados principalmente através destes grupos e através das unidades sanitárias e outras entidades ligadas à emergência. Tais ligações são melhor estabelecidas nas actividades em curso de preparação à emergência e assegurando que os representantes de acções relacionadas com o HIV 'não ligadas à emergência' constituam uma parte fundamental de preparação para fazer face à emergência e preparação de planos de contingência nas zonas propensas às emergências repentinas e lentas.
- Seria interessante explorar as experiências de migração dos jovens e em particular ver se existe uma ligação com os actuais níveis de pobreza.
- Com um maior envolvimento dos grupos locais de prevenção do HIV, cuidados e apoio (ou um órgão de coordenação tal como a MONASO) na planificação das acções de preparação para fazer face à emergência, seria mais fácil assegurar que estes serviços sejam acessíveis às pessoas vivendo com HIV ou às pessoas vulneráveis ao HIV.

Impacto da emergência sobre as pessoas vivendo com HIV e os grupos afectados

- Seria útil compreender a escala e o impacto das actividades de ganho - ganho a serem levadas a cabo pelos rapazes e pelas raparigas depois de uma situação de emergência. Em particular, seria útil compreender mais sobre o que seriam os riscos em relação à desistência nas escolas, abuso sexual ou físico, impacto familiar a longo prazo e o tipo de criança que desenvolve tal trabalho.
- Seria útil compreender mais o que seria o impacto de uma emergência repentina sobre as opções em termos de meios de subsistência das pessoas vivendo com HIV.

Impacto sobre a provisão de serviços

- Em situações onde as pessoas são deslocadas durante uma emergência, existe uma oportunidade de melhorar o acesso ao aconselhamento, teste e – onde for necessário – tratamento, cuidados e apoio às pessoas vivendo com HIV.
- A futura preparação de planos de contingência deve identificar intervenções de cuidados domiciliários na preparação para fazer face à emergência. O seu papel durante o período em que as pessoas estiverem deslocadas seria de assegurar a continuação do fornecimento regular de bens, que as infra-estuturas tais como água e saneamento do meio sejam providenciadas e que não afectem de forma adversa os doentes crónicos.
- A prevenção da malária constitui uma prioridade para as pessoas vivendo com o HIV. As intervenções à emergência podem facilitar o acesso à informação sobre a prevenção da malária, às redes mosquiteiras impregnadas e aos cuidados com a malária para todas as pessoas, e em particular para as pessoas vivendo com HIV, especialmente as mulheres grávidas.

- A desistência ao tratamento deve ser abordada com mais rigor com vista a identificar as causas individuais para além da falta de alimentos, em situações onde a distribuição de alimentos tenha ocorrido vários anos.

Impacto sobre os meios de subsistência

- Será importante rever o impacto das avaliações dos projectos de mitigação financiados pelo CNCS e ver se os projectos já analisaram as necessidades de determinados meios de subsistência (constrangimentos em termos de trabalho, necessidade de estar baseado próximo a um centro de tratamento, impacto da discriminação anterior tal como a perda de terra ou bens depois de se tornar viúva/viúvo) e integrá-los nos programas.
- Existem vários estudos recentes sobre a integração do HIV em programas de meios de subsistência na África Austral. Será útil aplicar e adaptar lições adequadas nos programas de recuperação de meios de subsistência imediatos e a longo prazo.

Conclusões

O estudo constatou que os desastres naturais de impacto rápido e os de impacto lento aumentam o risco de transmissão do HIV nas mulheres, especialmente nas mulheres jovens. Contudo, este risco pode estar oculto e não é necessariamente reconhecido como uma violência sexual e baseada no género pelas comunidades onde isso acontece. A ‘vulnerabilidade oculta’ das mulheres e da raparigas que enfrentam uma deslocação relativamente menor tem implicações significativas para o seu risco em relação ao HIV.

Aparentemente, as cheias não tem um impacto negativo, forte e a duradouro sobre as pessoas vivendo com HIV porque parece que a deslocação localizada, e o facto de as cheias terem ocorrido em locais onde houve poucas infra-estruturas de saúde, não causaram a interrupção do tratamento e dos cuidados. Isto pode ser mais grave quando um determinado número de pessoas estiver a fazer tratamento. Tendo em conta que houve acções de resposta à emergência tais como o controlo da malária e água e saneamento, parece que as pessoas vivendo com HIV não foram adversamente afectadas. O estigma não foi visto como um factor que iria reduzir o acesso aos cuidados de saúde e aos outros cuidados, tendo em conta as altas taxa de prevenção em todo o país.

Em contraste, as emergência lentas tais como a seca tiveram um impacto significativo sobre a capacidade das pessoas vivendo com HIV para acederem e aderirem à terapia anti-retroviral. Contudo, o aspecto pouco claro entre a pobreza crónica e uma ‘fase aguda de um problema crónico’ torna mais difícil definir determinadas acções para a emergência. O estudo indica que os agregados familiares afectados pelo HIV e as pessoas parece que consideram mais difícil lidar com as suas necessidades imediatas durante uma situação de crise prolongada, em comparação com a população não afectada pelo HIV, e têm menor probabilidade de se recompor dela. No entanto, tal deve ser explorado mais profundamente.

Os agregados familiares já afectados pelo HIV – em particular, as famílias chefiadas por pessoas idosas e crianças órfãs – tiveram mais perdas durante a emergência repentina e pareciam menos capazes de regressar aos seus meios de subsistência antes da ocorrência do desastre. Este foi menos obviamente o caso do contexto de desastres lentos mas é provável que seja o mesmo caso. A conclusão geral é que os agregados familiares já afectados pelo HIV esforçam-se mais do que os seus vizinhos não afectados pelo HIV, para satisfazerem as suas necessidades imediatas e para mudarem as suas estratégias de sobrevivência por forma que ambos reduzam as suas opções em termos de meios de subsistência a médio prazo e, possivelmente, aumentem também a sua vulnerabilidade a longo prazo em relação ao HIV.

1. Introduction

This case study forms part of a larger study, undertaken by the Overseas Development Institute (ODI) in partnership with the World Food Programme (WFP) and UNAIDS. The overall objective is to gain a better understanding of the various emergency settings and their implications for HIV and AIDS.

Five countries have been chosen for field work, representing different levels of HIV prevalence and emergency. Mozambique was selected because of its high HIV prevalence and regular slow-onset and rapid onset emergencies – drought, flood and cyclone. The study examines the experiences of those directly affected by HIV before, during and after the emergency and how the emergency and the response impact on their vulnerability and resilience. The other four countries are: Kenya, Central African Republic, Haiti and Sri Lanka.

The study is based on field work in two areas. Caia district is one of the districts that was affected by a flood in February 2007. There was also a cyclone nearer the coast at the same time which also led to flooding. Overall, 107,500 people were displaced. Guijá District is in Gaza Province and suffers cyclical and chronic drought. Guijá had a severe drought in 2005 and parts of the district are considered to have a possible drought in the near future.

2. Methodology

The study used the following methods:

- Desk review, including internet search and identification of grey literature
- Key informant interviews at national and regional level involved in the emergency response and/or HIV programming
- Field visits: a brief field visit to Gaza Province (Guijá District plus partners in Chókwé District) for two days; a five-day field visit to Caia and Marromeu Districts, Sofala Province, including Chupanga resettlement centre.

Focus group discussions were held with community members directly affected by emergencies (including displaced people in Caia) and with sex workers and people living with HIV. In this latter category, there was one FGD of this kind in Guijá, being a discussion with eight community representatives, some of whom were trained HIV or home-based care volunteers working with a local NGO. In Caia, FGDs were held with one group of five sex workers who were informally approached in their place of work; with two groups of people living with HIV (8 representatives of the Mwatipedza Association in Caia Town and 21 people from Caia Health Centre); and with 27 community members living in former accommodation centres which had been converted into resettlement centres in Chupanga District. In all cases, the objectives of the interview were explained and people were given the opportunity of giving their names or maintaining anonymity. In-depth interviews were held with key stakeholders (government, UN, INGO and NNGO representatives either directly involved in the emergency or HIV response), nationally and at district level. Interviews followed a guide (see Annex 2) although the discussions were fluid and where possible enabled interviewees to speak freely.

Several constraints were encountered. There was limited time available for the study. Consequently the visit to Gaza province did not allow time for discussions with people living with HIV or many community representatives and so findings from this site should be seen as tentative. It was felt by the consultants that Mozambique's 'disaster context' would be incomplete without looking both at the rapid onset and slow onset disasters, hence the Gaza site visit was felt to be important despite its tentative findings. The field visit to Caia coincided with a visit by the provincial

governor, which limited opportunities to talk to key informants at district level since several FGDs had to be cancelled at the last minute.

A common challenge in Mozambique is the limited data available on HIV or on the underlying drivers of the epidemic. Information on district or sub-district health service access and utilisation or data on sub-district HIV prevalence is often absent. There is also limited data about HIV actors and services within many districts, especially at community level.

There is a vigorous debate at both policy and programming level on the complex linkages between chronic food insecurity, poverty and HIV in Southern Africa. In simple terms, the economic shocks suffered by households when a member becomes infected with HIV (loss of income and health and funeral expenses, for example) are extreme, as are the economic shocks suffered during a prolonged slow-onset emergency, such as a drought (e.g. loss of assets). How far a household is able to recover depends on the extent to which it can recover the assets that it had to spend during the crisis. Both HIV and chronic drought make it much harder for a household to recover. This complex relationship was a methodological challenge during the study, especially in Gaza Province, because the long history of both emergency assistance and direct support on HIV at times became interlinked. External assistance received in the acute phase of an emergency is intended to assist the household to recover. However, the ongoing chronic drought plus HIV impact reduce the likelihood that an affected household will be able to recover their assets, thus requiring longer-term and different interventions. As findings in this report show, the need to provide interventions at local level to support both HIV-affected households and drought-affected households in the immediate term, whilst attempting to develop longer-term sustainable livelihoods, blur the lines at an operational level, thus making it more difficult to distinguish between the impacts of chronic poverty, slow-onset emergency and prolonged crisis.

3. Country context

Mozambique has faced grinding poverty, conflict and more than the usual number of natural disasters. It is one of the ten poorest countries in the world.¹ A civil war, backed by external forces including Rhodesian and apartheid South African governments, lasted for 16 years and left rural infrastructure damaged or destroyed and large portions of arable land infested with landmines.

Mozambique has made enormous economic and social gains since the peace accord in 1992. From being ranking lowest in UNDP's Human Development Index in 1992, Mozambique is now ranked 168 out of 177. GDP grew at an average 8.9% between 1997 and 2003. The proportion of Mozambican population living below the national poverty line² declined from 69% in 1996 to 54% in 2003. The eradication of absolute poverty is the foremost priority of the government. The second Action Plan for the Reduction of Absolute Poverty (PARPA II), which is the principle strategy for the reduction of poverty in the country, contains explicit references to poverty reduction and greater geographical equity of economic development.

However, the rapid economic growth is striking partly because of the very low starting point at which it is being measured. The economy is still very weak and growth is largely not translating into benefits for the poor. Economic growth is mainly in the transport and construction sectors, not in agricultural production upon which most of the population is dependent (Government of Mozambique/Programme Aid Partners, 2006). Income inequality has increased and there are huge regional disparities and gender inequality. Over half of the population live in absolute poverty.

¹ All data unless otherwise cited from UNDP, 2006, *Mozambique National Human Development Report 2005: Human Development to 2015 Reaching for the Millennium Development Goals*; UNDP, 2007, *Human Development Report 2006* and UNICEF, 2006, *State of the World's Children 2007*.

² The GOM definition is the inability to meet a specific set of calorie and basic consumption items (consumption-based poverty line), but in practice this is taken to mean living on less than US\$1 per day.

Mozambique is very dependant on donor assistance, which in 2004 and 2005 was equivalent to 20% of the gross domestic product.

Natural disasters play an important role both as a cause and a consequence of poverty. Floods and cyclones destroy the emerging infrastructure and communication systems and devastate household and commercial economic assets.

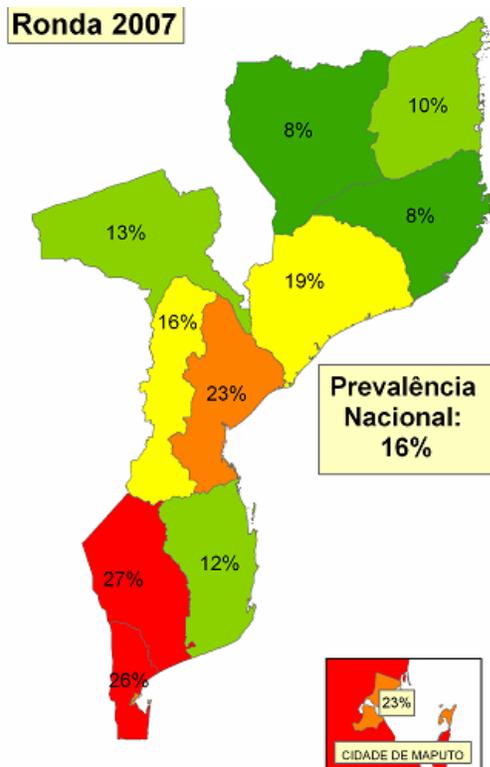
3.1 HIV epidemiology

Overall prevalence rates and geographical differences

Mozambique's HIV epidemic started later than the surrounding countries, probably 'protected' by the limited movement of people during the civil war. It is now one of the fastest growing epidemics in the world. Adult prevalence rate is 16% according to the latest antenatal prevalence data. This hides huge disparities within the country. Rates vary from 8% in Niassa and Nampula provinces in the north to 27% in Gaza Province and 26% in Maputo province,³ up to 34.4% in Beira city, Sofala province (Republic of Mozambique, 2005). There is still very limited HIV data available below provincial level.

HIV prevalence illustrates great gender inequities, which are particularly acute in young women, with three HIV-positive young women to every HIV-positive young man (Republic of Mozambique, 2006).

Map 1: Provincial HIV prevalence rates, December 2007



Prevention

³ Most recent HIV data released by Government of Mozambique on 1 December 2007.

The majority of Mozambicans, living in rural areas or poor peri-urban areas have very limited access to HIV-related education and preventive health services. Knowledge of HIV is still low with only one third of young men and one fifth of young women having 'comprehensive knowledge' of HIV nationally – lower in rural areas (UNICEF, 2006a). The age of sexual debut is low (average 16 years for girls) and condom use and HIV testing by youth is low. In the 2003, Demographic and Health Survey, only 29% of women and 33% of young women and men aged 15 to 24 used condoms the last time they had sex with a casual partner (Republic of Mozambique, 2006). Some of the most vulnerable individuals and communities are girls and young women in vulnerable situations such as school hostels or next to transport corridors, men working on transport construction sites, female and male migrant workers and poor rural communities that have historically relied on migration labour as part of livelihood strategies.

A recent World Bank assessment of the National AIDS Commission (CNCS) highlights the necessity for a prevention campaign that focuses on the currently known drivers of change: high levels of older men having sex with younger women; multiple concurrent partnerships (assumed to be happening but with little data to back this up), low levels of condom use, with unequal gender relationships (World Bank 2007). There has recently been growing political commitment to the need for more and improved prevention activities, including support for mass testing promotion.

Poverty and already high levels of death and disease make it hard for people to take preventive steps. 'As Mozambique emerges from the mantle of the war and new opportunities present themselves... the sense of living for the immediate future, preparing the way for your family and providing monetary stability in the home eclipses fears of contracting an incurable 'disease' (Selvester 2006). Economic choices are complex and there are few studies that have identified appropriate behaviour change interventions.

Treatment, care and support

It is estimated that about 1.3 million adults and children were living with HIV in 2003. There has been rapid rollout of treatment in the public health sector in the past two years. ART access is increasing by at least 6,000 new patients per month and had surpassed 75,000 people by August 2007.⁴ Treatment and associated health costs (CD4 counts, for example) are free, although indirect costs such as transport still remain a barrier to many. In particular, access in rural areas is limited. The roll-out plan for ART concentrated firstly on getting ART available in every district in the country (which has now been achieved, with 209 facilities providing ART) starting with the main district health facility. There is now a plan to further roll out treatment to the periphery, although lack of qualified health personnel is a challenge, as is the overall weak health infrastructure.

VCT access has not kept pace with ART and a recent change in policy, limiting the number of 'stand alone' VCT centres has possibly slowed the pace of access further. This lack of VCT facilities has very recently been recognised, with a proposed community mobilisation campaign on testing. This is at a very preliminary phase of planning, and at the time of the study no operational plans had been prepared. At the time of the study there were fewer VCT facilities available, especially in rural districts, than treatment. In Guijá, VCT was available within the health centre but there were no mobile VCT services or in other health posts.

Similar to many other countries, PMTCT roll out has received less emphasis than ART – possibly because of a need to focus on strengthened mother and child health services as a requirement for effective PMTCT, or possibly due to gender inequalities leading to less interest in or focus on women living with HIV. In 2006, less than 5% of HIV-positive pregnant women received a complete course of ARV prophylaxis to reduce mother-to-child transmission and less than 3% of children living with HIV and eligible for treatment were receiving treatment (although this number has since increased) (Republic of Mozambique, 2006a).

⁴ Information provided by UNAIDS from MOH data August 2007.

The burden of care is largely hidden, with huge numbers of sick people going home to die in rural areas and few testing and treatment facilities in rural areas. This was very apparent during the study, especially in the flood-affected sites, where few people were living openly with HIV and high levels of denial and/or ignorance about the cause of chronic illness.

Stigma remains an enormous challenge in Mozambique. Partly this is due to low levels of testing and relatively recent access to an effective anti-retroviral therapy for people who do test positive. Overall lack of knowledge about HIV in the country and strong beliefs about traditional causes of illness increase the potential for stigma, with accusations of witchcraft commonly being levelled against older people.⁵

Home based care (HBC) is primarily provided by small local NGOs or CBOs and over the past few years, MMAS and the Ministry of Health (Ministério de Saúde, MISAU) have been working to ensure that groups aiming to provide HBC receive training, kits and ongoing support. Others without this training are designated 'home visiting programmes'. Currently there are still a relatively small number of HBC groups.

Impact mitigation

There is a weak network of effective support for people living with HIV and still very high levels of stigma.⁶ There are few if any well-known figures who have openly declared their status at local or national level. The national network of people living with HIV, RENSIDA, is still small and has limited funding, staffing or significant experience. People living with HIV do not have an earmarked seat at provincial or district HIV coordinating structures, for example. Despite the large overall HIV resource pool in Mozambique, associations of people living with HIV do not have a specific funding line for resources for their prevention, support or impact mitigation activities (possibly because of the low recognition of the needs and rights of people living with HIV in the national policy context). An assessment of the national context for people living with HIV found that the majority of groups were focusing primarily on income generating projects of short or medium duration, largely following the donor requirements, rather than being able to actively set an agenda or advocate for their rights at local up to national level (Chilungo & Saulene, 2006). It is clear from discussions and literature review also that few of these projects are grounded on a solid market analysis or are responsive to the particular livelihoods needs of people living with HIV. The same report found that the majority of small associations are comprised primarily of women (although the majority of representatives are male).

Approximately 1.5 million children have lost one or both parents – roughly 15% of all children in the country (Republic of Mozambique/MMAS, 2006). The national plan of action on orphans and vulnerable children highlights the importance of targeting support to both orphans and vulnerable non-orphans. There is no coordinated registration or tracking of OVC at district, provincial or national level at present although this forms part of the Plan of Action. A national vulnerability analysis determined that maternal orphans are significantly more likely to be malnourished than non-orphans (SETSAN, 2006). Many of these live with elderly and already impoverished grandparents. In one programme supporting elderly care givers, in Tete Province, over the first 2 years of the project the number of older carers increased by 330% and orphaned children increased by 287%. Over 70% of the older carers are women (HelpAge International/International HIV/AIDS Alliance, 2003). One study in Zambézia (part of the flood-affected area in 2007) found that 12% of all household heads were over 55 years and 4.3% were under the age of 20 years (SC Alliance & HACI OVC Baseline Study Sept 2004). The national plan of action calls for a basic package of support to OVC, including nutrition, education and protection. Some interventions are being piloted in Tete and Sofala Province but it was not possible to access information about these interventions at this stage. The impression is that they continue to remain piecemeal.

⁵ Interview with Senhor Doda, VUKOXA, Chókwé.

⁶ Interviews with RENSIDA and International HIV/AIDS Alliance.

The Ministry of Women and Social Action (MMAS) also has a mandate to provide social protection for vulnerable groups. This includes a small food subsidy programme (Programa de Subsídio de Alimentos) which is a very limited cash subsidy for the elderly, disabled, drug addicts, malnourished women and children and the chronically ill (but not those living with HIV and TB). In March 2007 there were 101,800 beneficiaries (RVHP, 2007). People living with HIV are entitled to immediate short-term emergency assistance and this has been the reason why it has been argued that they are excluded from the PSA, although access to a long-term and predictable income is a very different type of support to a one off assistance in kind. They also provide direct assistance (milk powder or school supplies) as short term emergency assistance to vulnerable elder care givers and orphans and vulnerable children (OVC), community development projects and, more recently, a basic food basket and school feeding programme for OVC which is being supported by WFP. Overall coverage is limited. The social protection debate is slowly emerging, but current policy prioritises support for economic activities or 'in kind' support.

Policy environment

Mozambique is signatory to international commitments such as the UNGASS Declaration of Commitment. It conforms to the 'Three Ones' principles. Mozambique's National AIDS Council (CNCS) Strategic Plan (PEN II) 2005-9 is a multisectoral response, reinforced in Mozambique's current five-year plan for government, 2005-9, in which HIV/AIDS is addressed under the human and social development pillar. PEN II has an overall target of reducing the number of new infections from 500 to 300 per day by 2009). There are seven pillars of action, including advocacy, reducing stigma and discrimination of people living with HIV, treatment, including ARVs and treatment of opportunistic infections, mitigation, research, and coordination.

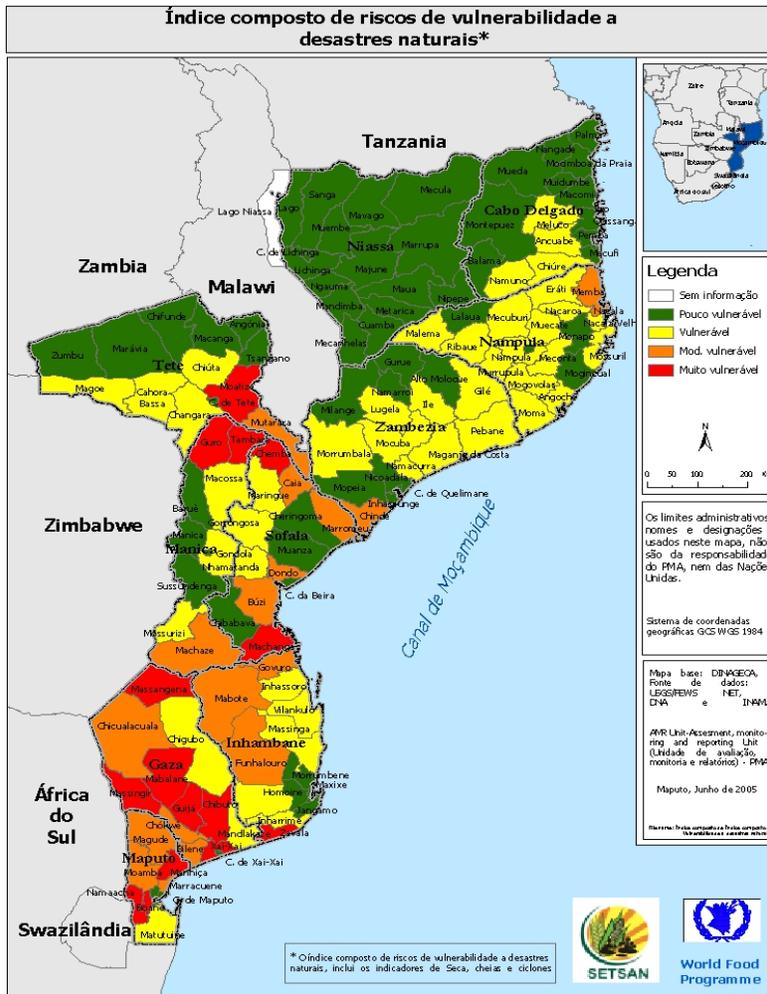
The Ministry of Health also has a policy and operational plan, the Strategic Plan for the Health Sector (PEN-Saude) 2004-8. The plan has a balance between a necessary focus on prevention but recognition of the need for a comprehensive prevention, care, treatment and support framework. It includes PMTCT and ART along with a range of other prevention and care initiatives. However, in practice it appears that much of the donor contribution through SWAps focuses on ART and less so on services such as reduction of sexual transmission (condoms, STI diagnosis & treatment, youth friendly services), PMTCT or community-based support.

The majority of sectoral ministries have HIV and AIDS strategies using similar 'pillars' to those of PEN II. There appears to be limited coordination at policy and strategy level between the emergency response initiatives that focus on food security, the social safety nets programme for the most vulnerable and HIV prevention, care or support. Coordination remains a challenge.

3.2 History of emergency

Mozambique is prone to a wide range of natural disasters: cyclones, drought and flooding. The country is reliant on rain-fed subsistence agriculture as a mainstay for livelihoods, which means that natural disasters have an immediate and profound impact both for those directly affected but also for the economy as a whole. Of Mozambique's 128 districts, 20 are "highly prone to drought"; 30 to flooding; and another 7 to both risks. Overall, 48.2% of the population is prone to one or both risks (FAO, 2007).

Map 2: Composite index of vulnerability risk to natural disasters, SETSAN/WFP 2006



Map includes vulnerability to drought, flood and cyclone

Green indicates little vulnerability;
 yellow = vulnerable;
 orange = moderately vulnerable;
 red = highly vulnerable

From 1990 – 2007 an estimated 9,900,000 people were affected by either floods, drought or cyclones. Data from the national disaster coordination body (Instituto Nacional de Gestão de Calamidades, INGC) assumes that an average of 500,000 people are likely to be affected by rapid onset flooding and cyclones and/or slow onset drought each year for at least the next 5-15 years (personal communication).⁷ At the time of writing this report, flood is again a serious problem in

the centre of the country.

Summary of type of emergency and impact

Year	Type of emergency	Impact
1992-3	Severe drought across Southern Africa	Especially severe due to being the first planting season after the end of the war
1999	Floods in Inhambane province	(Data on impact not identified)
2000	Cyclone and extensive flooding in the southern and central regions of Mozambique,	700 people dead, approx 500,000 people displaced. Total losses estimated at 20% of GNI.
2001	Floods in lower Zambezi valley	81 people killed; 155,000 people displaced
2002-2005	Severe drought in southern and central Mozambique(as well as neighbouring countries of Swaziland, Zimbabwe and Malawi)	Especially hard in flood-affected areas which had been left with few or no reserves

⁷ According to information provided by K Selvester based on INGC contingency reports 2006.

2006	Earthquake activity registered	While not severely affecting lives or livelihoods, adds to the sense of insecurity in the country
Feb 2007	Cyclone Fávio in Inhambane province; flooding of the lower Zambezi Valley	46,500 people affected by heavy rains which affected crops in South and coastal zone 285,000 people directly affected by floods, including 107,500 displaced
End 2007 / early 2008	At the time of writing this report heavy rains were leading to significant increases in water levels, in particular at the Cabora Bassa Dam. It is currently anticipated that there will be major displacement of population within Mozambique, with estimates reaching the potential damage and displacement experienced in 2000-1.	

Although ‘natural’, these emergencies are influenced by human intervention. There have been major floods on the Zambezi every five to ten years, but construction of dams (Kariba and Cabora Bassa) and changed water management and use across the Southern African region over the past forty years has altered this pattern. The dams led to a reduction in annual floods, making it easier for people to settle on the fertile flood prone lands. However, at times, notably in the big floods in 2000/1, rapid opening of the dams upstream cause rapid and huge devastation in Mozambique.

If global warming predictions are correct, Mozambique may well expect more, and more intense drought, cyclones and droughts in the coming years, with a projected 1.5-3°C increase for intermediate global warming scenarios, and a 10%–15% decline in average annual rainfall, much of it in the growing season (Dixon et al, 2003).

Vulnerable communities

All people living in the major river basins in the centre of the country and who live in the low-lying fertile areas are prone to floods. Although there is an attempt to resettle people in higher lands, many people choose to live in the more fertile areas close to the river.⁸ Given the relatively short-term nature of the floods, the main impact of the emergency is usually seen as being a short-term disruption to livelihoods. Damage to infrastructure (schools, health centres, roads) was more extreme in the earlier floods and in the cyclone affected area. it was not a significant challenge in the 2007 floods. However, as this report considers, the longer-term impact on people’s HIV vulnerability covers a broader range of factors than the immediate livelihoods damage.

In the south and centre of the country, the majority of the population are reliant on rain fed subsistence agriculture. The staple crop is maize and attempts to introduce more drought-resistant cereal varieties have so far had limited success. When rains fail, people with no alternative sources of income or people without savings or investments in goods or money are unable to feed themselves. As long as local markets can sell food, households are able to sell off assets temporarily to survive until the next planting season. However, the ability to cope with this short-term shock is limited in households that lack labour, have lost alternative sources of income (such as migrant labour remittances) and have higher HIV-related costs such as health care.

A vulnerability survey on the impact of the drought and floods in 2007/7 by the national Technical Group on Food Security and Nutrition (SETSAN) found that 43% of the sample were female-headed households in the cyclone-affected zone and drought-affected areas respectively (with high labour migration and higher HIV prevalence), In the flood-affected area only 13% were female headed. During the 2006 flood and drought, there was sufficient staple food in the country

⁸ It was not possible to identify any data on the types of household (wealth, activity etc) who opt to resettle or to stay. This may have an impact on the type of resettlement and on the HIV linkages. In particular, low-labour households (elderly heads of household, households affected by chronic illness, households with no male labour) are likely to have different livelihoods options.

complemented by commercial imports despite local shortages because of deficits and lack of market access. People reported changing their livelihood coping mechanisms. In the drought areas, there was an increase in the numbers of households relying on piece work as the main income source, whereas in the flood-affected areas people tended to increase sale of their livestock assets. The fact that HIV has an impact on household composition and on livelihoods options is important to bear in mind.

Policy context and coordination

The government established a national institute for disaster management in 2000, Instituto Nacional de Gestão de Calamidades (INGC). INGC's current strategic plan places emphasis on its coordination role. In the 2007 cyclone and floods, INGC was consistently praised as having a strong response and a lead coordination role (Cosgrave et al, May 2007). INGC has an additional mandate for reclaiming and rehabilitating land and marginal economies in emergency prone areas. INGC acknowledges the strong link between livelihoods, economic development in the agricultural sector and longer-term emergency mitigation.

The humanitarian community is also well coordinated, through a joint UN programme. The cluster approach used in the 2007 emergency was generally assumed to be effective by both UN and NGO actors.

The 'triple threat' of chronic and growing poverty, impact of HIV and poor governance (leading to inappropriate or lack of policies that would provide a longer-term development solution to some of the above challenges) are ongoing. When a temporary harvest failure due to drought or flood affects such populations it becomes increasingly harder for the most vulnerable to cope. (This includes farming households who lose crops or cannot sell crops, non-farming poor households who cannot afford basic food stuffs at increased prices, and those who are unable to work due to lack of employment opportunities or illness, disability or age. This growing level of chronic poverty, and a growing number of people becoming progressively poorer after each shock, is increasing across the region (Mauder & Wiggins, 2007). This is clearly the case in the drought-prone areas in Mozambique.

3.3 Livelihood contexts

Over 80% of the Mozambican population depends on small-scale subsistence farming. There is a lot of land available for farming (only 10% of arable land is under cultivation) but there are acute shortages of labour, absence of draught power, access to water, appropriate seed varieties and markets. In the South there has historically been a reliance on (male) migrant labour, mostly to South African mines. Remittances have formed a substantial part of household income in Gaza and Inhambane provinces in particular. With significant retrenchment from the mines, this source of income has reduced. Migration continues, but remittances are far lower and unpredictable. Poorer households rely on both sale of labour for piece work (*ganho ganho*) or petty trading. This is often undertaken by children or women. In Caia and Morrumbala districts a recent study showed that two-thirds of children are involved in farming, petty trading, piece work (*ganho ganho*) or working in the commercial trading posts by the river. The children who do this regularly have lost a mother or a father (Save the Children UK & Norway, 2006).

Few people find employment in the private sector, which is relatively small in Mozambique. There is a small commercial agriculture sector which provides limited employment (such as the commercial market gardening near Guijá District in Gaza) and commercial cotton and other cash crops further north. The majority of new employment in disaster-affected areas are related to road and infrastructure construction. Although there is a small commercial agriculture sector and some emerging industries, these are very small and provide limited employment.

A recent vulnerability assessment based on livelihood analysis estimates that 34.4% of households are food insecure (SETSAN 2006). Two livelihood groups are seen as especially vulnerable –

households reliant on low income labour such as piece work in other people's farms or in the informal sector, and households with marginal livelihoods, where income or food production does not provide enough to eat for the whole year. Government policy for these households is firstly to promote long-term and sustainable economic growth, focusing on agricultural development. In disaster situations, distribution of agricultural inputs, often through agricultural input fairs. As mentioned above, there is a limited social safety nets programme but as yet no national social protection policy.

The majority of the poorest households are female headed. They also tend to have the highest number of dependents per household (SETSAN, 2006). Although both men and women have always worked in the fields, there has historically been a division of labour. Subsistence agriculture requires a lot of hard physical labour. Female headed households, or those headed by the elderly or chronically ill, struggle to prepare fields. Several alternative options for diversifying livelihoods are not usually undertaken by women – fishing or migrating for labour, for example. The main source of alternative income for women is petty trading, which exposes women to transactional sex, as is discussed later.

3.4 Health environment prior to the emergency

Total expenditure on health per capita in 2004 was US\$42 and total expenditure on health as a percentage of GDP was 4% in 2004, according to WHO. There is limited access to services such as education, health and safe water and sanitation. Under-5 mortality is 145/1,000 live births and 41% of all children are stunted (have chronic malnutrition), which demonstrates the high overall poverty levels. Stunting in children leads to long-term and irreversible damage to health and to intellectual development.

Use and access of health care is still extremely weak. It is estimated that 12% of the population lives more than 3 hours from the nearest health facility and there is one doctor for every 30,000 people. Two-thirds of rural people have to walk more than an hour to reach the closest health unit. Only 60% of the rural population has access to safe water. Communicable diseases, in particular malaria, are the biggest killers of children. For example, it is estimated that malaria accounts for 60% of children in hospital and 30% of deaths (DFID Mozambique factsheet, September 2007). There is limited documentation about health seeking behaviour, but qualitative research shows that the majority of people still prefer to visit traditional doctors (*curandeiros*) than government health facilities (Republic of Mozambique, 2004). Mozambique, similarly to its neighbours, faces a crisis of insufficiently trained staff with low morale because of difficult work conditions and low salaries. With all of these challenges, the roll out of complex HIV health services has been impressive.

3.5 Cultural context prior to the emergency

The national HIV strategic plan identifies the following cultural factors that increase the risk of HIV transmission:

- Women's unequal access to resources, illiteracy, economic dependence and lack of power and authority within the home and society in general.
- High levels of sexual violence and coercive sex, primarily against girls and women but also (rarely documented) by men against men. In one piece of research with youths, an equal number of girls and boys (26%) replied that a man has the right to hit his partner when she refuses sexual relationships. 40% of girls interviewed reported that they had been coerced into sex. One NGO registered 893 cases of domestic violence in 2002, yet only 16 of these cases were prosecuted (UNICEF, 2004).⁹ In a 2004 Youth Profile commissioned by the Ministry of

⁹ All additional data in this section, unless otherwise referenced, sourced from this factsheet.

Youth and Sport and UNICEF, 20% of girls who participated in the study reported that abuse was a problem in schools (UNICEF, 2006).

- Unwillingness to send girls to school, leading to lower literacy levels in girls than boys.
- Cultural practices that include unsafe sex. Death is traditionally seen to contaminate the remaining spouse. Widows are expected to undergo sexual purification or cleansing (*ku tchinga* in Guijá and Chókweé districts) with another man, generally someone closely related to the deceased husband. The cleansing is not seen as effective if condoms are used.¹⁰ Initiation rites are also highly prevalent for girls and boys in all rural parts of the country. There are many positive aspects to this education but there are also disadvantages including the strong focus on male dominance in sexual relations.
- Child marriage is prevalent. DHS data from 2003 indicate that 18% of young women aged 20-24 had been married before the age of 15 and 56 % before the age of 18. This is a particular challenge when it comes to HIV prevention, because married girls are no longer 'girls' and therefore inadvertently excluded from targeted youth HIV prevention campaigns, for example. (Republic of Mozambique/CNCS, 2004).

In addition to the factors cited above, a number of factors appear to make younger women especially vulnerable to HIV and indicate some of the reasons why HIV infection rates are so much higher in younger women than any other age group. Young girls are less able to negotiate condom use than older women (especially when they are married), the age differential at sexual debut and at marriage is very high and hence girls and young women are having sex with men who are older and therefore more likely to have been exposed to HIV risk. In addition, when sexual organs are not yet mature, there is increasing vulnerability to tearing, etc, and therefore HIV transmission. This is increased during coerced sex.

Gender inequity also leads to less access to resources and information for women and girls, thereby increasing their vulnerability to HIV. Traditional inheritance law, for example, denies widows and orphans the right to inherit land and assets. This is more commonly observed than the recent (1997) Land Law which states that women and men have equal rights to customary and state-allocated land. There is limited access to legal assistance in these cases. Few women, especially in rural areas, know and understand their legal rights to land and customary practices.¹¹ Gender inequality is also reflected in school attendance, with lower female school attendance at both primary and secondary level. This further restricts girls' and women's access to information that could assist them in reducing HIV vulnerability.

4. Programmatic responses

This report looks in more detail at the responses to the February 2007 floods that affected Manica, Tete, Sofala and Zambézia Province and to the ongoing chronic drought in southern Mozambique of which 2005/6 was the most recent acute episode.

4.1 What was the emergency response?

*Response to floods:*¹²

¹⁰ Several informants in Gaza Province referred to this practice. The doctor at the main ART hospital in Chókwé said that almost all of her female patients feel the need to purify themselves. In many cases where the family accepts that this should not be done ritually, the woman has sex with someone unknown passing through on the main road. This practice was also referred to by other community-based NGO staff and activists and is clearly deeply entrenched.

¹¹ Vukoxa in Chókwé District trains elderly para-legals in response to this problem. There were few other examples of legal aid available in the sites visited although the problem of property grabbing was a common NGO concern and several groups felt it would be important to address this issue.

¹² Information in this section primarily drawn from Cosgrave et al (2007) plus interviews with key informants.

The response to the 2007 cyclone and flood was coordinated by the INGC, with a central coordinating structure plus regional bases, including one in Caia. INGC was overall responsible for the response and the 'humanitarian community' (UN and INGOs primarily) supported this although there was a level of duplication reported in the early days of the reports, according to a real time evaluation of the cluster approach conducted in April 2007 (Cosgrave et al, 2007).

The response to the flood was well-coordinated. Simulation exercises coordinated by INGC at the end of 2006, and a functioning early warning system meant that as the waters slowly rose, people were able to relocate with sufficient warning. 163,000 people were accommodated in 40 accommodation centres. Accommodation centres were designated sites on higher land, identified by the local government, which were intended to be used as short-term centres. The local population assisted in preparing of land and constructing simple accommodation. Tents were also provided immediately by humanitarian agencies and families were allocated tents and non. Water points were constructed locally although these seemed to be less rapidly constructed; in the meantime, displaced people shared existing water sources. There were approximately 3,500 to 4,000 people in each accommodation centre in Chupanga and numbers appear to be similar in others. In one resettlement centre in Chupanga Town there are just over 500 families. The numbers seem to vary between 80 families to 300 families, with most between 150 – 200 families. Details on who were in each centre are limited because during this response the policy was to not register people. This policy has since been altered. The majority of displacements were quite local – from the river basin area to higher land, usually no more than 15km from home.

There was sufficient warning about the floods so many people were able to move most of their portable assets. For example, it was reported that many households in accommodation camps had their *pilaus* (heavy wooden mortars and pestles for pounding maize) which are so heavy that they would have been left behind if people had to rush.

In the flood-affected areas, most people who were living in the flood plain went to accommodation centres on the high ground, which had already been designated in INGC contingency planning. Construction of the centres was coordinated by local government. Those in the accommodation centres received food and non-food items provided by both INGC and local humanitarian agencies. Allocation and distribution was coordinated by INGC as well as UN-led 'clusters' of coordinated action from UN and INGOs. Although there was some initial tension between locally coordinated government responses and the UN-led cluster approach, these were resolved relatively early.¹³

Those with fields in the low land but who were living on high ground did not receive food or non-food assistance. Assistance included shelter, water and sanitation provision in camps, agricultural inputs for those who had lost the crop (the flood occurred at harvest time) and protection interventions, for example education interventions in the camp. Humanitarian funding was partly included within existing government-planned emergency responses and substantial additional funding was mobilised through the UN-coordinated Central Emergency Response Fund (CERF) and arrived rapidly. The CERF called for US\$500 million and largely met its target (Cosgrave et al, 2007). There was also a significant level of national, private contributions.

The majority of health care in the emergency was provided by existing local health facilities. There were no disease epidemics, such as cholera. WHO reported no significantly increased morbidity or mortality in an emergency mission conducted in February 2007. However, it appears that already high levels of malaria and diarrhoeal disease deaths did not significantly decrease either. The main reason for this lack of increased mortality was seen as being effective service provision within the existing team, plus a relatively small displacement during the floods (WHO, 2007). There was no information available on bio-safety but it appears, according to the February 2007 WHO report, that

¹³ This information is provided in a real-time evaluation of the emergency response that was conducted in March 2007. This evaluation provides detailed information on how both the INGC and UN-led responses were implemented. (Cosgrave et al, 2007)

infection control resources were available. Condoms were available in health centres after an initial shortage. Most of the humanitarian agencies interviewed in this review reported distributing condoms and the National AIDS Control Programme also provided condoms for displaced populations. As will be seen later, there seems to have been more condoms available during the emergency than before and after.

The longer-term government response has been to declare that people should not return to the flood-prone lands.¹⁴ The proposed resettlement programme was severely delayed (at the time of this study) with the promised house construction severely delayed and many people choosing to return to their original land. Given that rains are predicted to be normal for this next planting season, there has been limited need for longer-term agricultural inputs. Section 5 provides more information on people's own perceptions of the response.¹⁵

Response to droughts

The main government focus for chronic drought areas is on longer-term improvements in the agricultural sector coupled with agricultural input fairs. However, there are frequent general food distributions, usually with food provided by WFP and coordinated by district administration. Although no drought or emergency has been declared this year, the numbers receiving general food distribution during the hungry months is still large. In Guijá District, for example, of the approximately 75.000 inhabitants, over 43.000 are considered to be drought-affected. Almost 25,000 (just under 5.000 households) of these will benefit from Food for Work programmes, 43.000 individuals will receive maize, rice and beans at a discounted price from INGC.

Much of the drought-affected area was also the epicentre of the 2000/1 floods when at least 700 people were killed and there was immense devastation. *'Since the floods in 2000 we have never had a good harvest... and food for work began in 2000'*. (Community member, Guijá) *'With the floods elderly people suffered more than others... an older person has spent many years since his or her youth gathering goods and lost all... and, since the floods in 2000 we have never been the same as we were before'*. (Sr Dode, Vukoxa Community Organisation, Chókwé). This was particularly felt to be the case for elderly-headed or female-headed households, many of whom would have been HIV-affected. No interviews were held with people living with HIV or HIV-affected households so it was not possible to get information directly from HIV-affected households.

Vulnerable group responses

There are a number of ongoing food aid interventions that are intended to reach HIV-affected (vulnerable) groups, provided by a range of government and non-government actors. These are provided across the country using a range of economic and social criteria for targeting. Criteria vary but include household income, dependency ratios, presence of someone with a chronic illness in the household. The interventions include:

- a) food support for people living with HIV who are enrolled in home based care (HBC) programmes. A basic food packet is delivered through local implementing partners;¹⁶

¹⁴ The issue of resettlement is contentious and, at the time of the report, was being discussed at national level in relation to longer-term recovery from the floods. There have been sporadic attempts at resettling people from flood-prone areas to higher lands. The first attempt was three years after Independence, after the very bad floods of 1978. This resettlement effort was part of the broader government project to promote the establishment of a settlement pattern of communal villages for easier provision of services such as health and education. However, this was widely disliked by local people (who refer to the 1978 flood as the 'villages' flood). The 2001 floods were followed by a concerted effort to have populations resettle, often on the same sites which had proved problematic in 1978. The same problem is currently recurring and has overtones of affiliation to political parties.

¹⁵ With more severe floods occurring just twelve months after the initial floods, in the same areas, the need for some form of resettlement plan may be increasingly acknowledged as unavoidable to local populations.

¹⁶ Currently partnerships and criteria are being assessed to improve selection criteria and processes associated with the particular role of food assistance within the care programme (nutritional support for the client and care/livelihood support to the household) and to identify appropriate exit strategies to limit the duration of food assistance to the absolute/effective minimum. A similar review and revision process is being carried out for the ART and programmes. Lessons from the OVC programme will be applied to inform the OVC programme.

- b) nutritional support for people on ART. This is primarily being delivered through partners in peri-urban areas but WFP is exploring means to provide food support via district health services. The aim of the programme is to provide sufficient nutrition to enable the sick person to take their medicine and recover sufficient weight to benefit from treatment. Household food baskets are provided to selected clients from extremely vulnerable households – the selection appears to depend on amount of food available and used on medical criteria and economic situation of the patient;
- c) nutritional support within PMTCT programming (for improved nutritional wellbeing of pregnant and lactating HIV+ women and their children);
- d) OVC support, integrated within a package of basic services including education and other support. The programme provides a basic daily food basket for each selected child (up to three children per household) compensating for their (food related) 'burden' on the household resources. The programme seeks to reduce livelihood related coping strategies that may compromise the protection and care of the children. The overall level of the food assistance programme is limited by a provincial quota/allocation out of the overall WFP OVC support programme.

4.2 How was HIV addressed in the emergency response?

Flood response

According to both interviews and reviews of existing evaluations, there was little focus on HIV at all in the immediate flood response. After the first few weeks, more attention was paid to HIV. In particular, a regular supply of condoms was provided via government health centres and humanitarian agency offices. Humanitarian agencies working within the accommodation centres identified and supported local theatre or community groups to conduct HIV sensitisation. Volunteers were apparently active in tracking down displaced people who were already on HIV treatment.

There were initiatives that focused on children, such as provision of emergency education centres. There were apparently no programmes specifically targeting the elderly, who form a large proportion of caregivers of sick adults and children.

There were some HIV responses introduced immediately or in the later rehabilitation phase:

- Some UN agencies and NGOs, especially UNICEF and Save the Children UK provided training on child protection and sexual exploitation, including HIV prevention. The training was provided for personnel responding to the emergency as well as community members. This included a focus on, for example, ensuring that latrine areas were well lit and designed in a way to reduce the risk of sexual assault.
- Condoms were provided via NGOs such as Oxfam Intermon¹⁷ and Concern, mostly sourced by PSI. CNCS and district health directorates facilitated condom access. One review of the accommodation centre mentioned limited or no condom access in the first few weeks in accommodation centre health facilities (WHO, 2007). Later reports and interviews reported a large amount of condom distribution using PSI and government sourced condoms distributed through health centres and during HIV sensitisation sessions in accommodation centres. It seems that condoms were not included in the initial response but this was later improved.
- Several agencies reported that they provided prevention information shortly after displacement, through the use of theatre groups or presentations in accommodation and resettlement areas.
- Groups that were already working on HIV prevention in the flood-affected areas, by and large, did not participate in the emergency response although it seems that some youth groups and prevention activists have been supported to continue prevention programming in the recovery phase. For example, one existing peer education project manager reported that '*Only the theatre group was mobilised by INGC to do theatre pieces about the floods and about cholera,*

¹⁷ Official name of Oxfam Spain

but this was nothing'. (Elena Medi, Health Manager, Projecto Consorcio, Caia). The MONASO focal point in Caia (MONASO is the network of AIDS service organisations), reported that *'during the floods we had to work every day... prioritising activities in accommodation centres. After the floods we are having coverage difficulties mostly because of lack of transport. During the floods we could share (get a lift) from other partners... the emergency finished and they went away.'* (José Filipa).

- CNCS provided an emergency fund for NGOs in the three affected provinces although this was announced some weeks after the floods. A call for proposals invited bids for emergency response and grants were awarded for 'impact mitigation' to 14 NGOs (Manica Province 4, Sofala Province 3, Zambézia Province 3 and Inhambane Province 4). NGOs having proposals approved.¹⁸ These grants are in the process of being implemented although apparently funding has not yet been distributed to all NGOs in all sites. There has not yet been any impact evaluation or reporting and some agencies have not received the funding for implementation. According to CNCS, the majority are focusing on including HIV prevention into rehabilitation programmes as well as some focus on targeting HIV-affected groups. It was not possible to get further information relating to the proposed use of grants, size of grant, coverage or impact.

However, the feedback during this study as well as existing evaluations of the response, accept that HIV was insufficiently integrated into the 2007 floods¹⁹. The main weaknesses include limited overlap between humanitarian personnel and those working on HIV, no ongoing engagement with HIV-specific agencies in contingency planning and response processes, no simple and accessible information on 'what to do',²⁰ and lack of local data on HIV making it harder to rapidly engage with existing interventions.

One critique that was highlighted in interviews was the overall lack of gender analysis in contingency planning or response, for example about the roles that men and women undertake, such as land clearing and house building which are traditionally male roles but which, during an emergency, need to be done rapidly and with all available hands. In the flood context, men were busy in the flood zone attempting to save as many crops and assets as possible whilst women and children moved to the accommodation centres.²¹

There is more focus on integrating HIV into the next round of floods and cyclones, with a dedicated emergency officer within UNAIDS being appointed by late 2007 and representation in the current contingency planning. Discussion of the real-time evaluation within the UN seems to have primarily driven this improvement; as well as a number of international initiatives such as increased focus on HIV within OCHA.²²

Drought response

There seem to be no HIV-specific emergency responses in drought-affected areas, with the exception of food assistance for vulnerable groups and an ongoing programme of training and awareness raising on sexual exploitation of women and children, incorporating HIV prevention, run by UNICEF and a number of NGOs. This includes training of community actors in drought-affected areas and is ongoing.

¹⁸ These included national NGOs with wide coverage, such as the Mozambican Red Cross and the Islamic Council, local NGOs and some INGOs such as World Vision and Save the Children Norway.

¹⁹ This is in particular with respect to information provided by the interagency real-time evaluation (Cosgrave et al, 2007) and interviews with Oxfam Intermon, Oxfam GB, Christian Aid, MONASO, UNAIDS.

²⁰ Guidelines, such as the Inter-agency Standing Committee (IASC) guidelines on HIV in emergencies had been circulated but both UN and INGO reported that it was hard to get the issues integrated once the emergency began and there was no time to review and plan. The guidelines were also described as being too long and non-specific to be of use to actors in the middle of a humanitarian response.

²¹ Several gender-specific examples were provided by Y Antonyo, Christian Aid, who felt that few agencies were aware of gender-specific vulnerabilities.

²² Based on information at regional and national level with UNAIDS, WFP and OCHA.

The ongoing 'vulnerable groups' distributions, have an explicit HIV targeting criteria, including households with someone with a chronic illness or high numbers of orphaned children within the home. It appears that there is an assumption that such targeting, which is usually undertaken by community leaders, ensures that HIV-affected people will have their food needs met. This is not necessarily the case and it was not possible to identify any monitoring that measured the efficacy of targeting. This is a WFP priority over the next two years or so.

There was no other specific HIV intervention during the emergency, relating to prevention or care and support that was reported.

5. The effects of the emergency

5.1 On vulnerable groups

5.1.1 Vulnerability

Increased vulnerability to HIV infection

The emergencies occurred in the context of already high levels of absolute poverty and HIV. What would have been a small event becomes an 'emergency' because of the scale of pre-existing vulnerabilities.

Did overall vulnerability lead to an increase in HIV infections? With very little HIV data available, and poor record keeping in areas such as STI treatment, there is limited evidence of increase in HIV transmission.²³ However, there was overwhelming evidence, reported by both community members and local service providers, that there was an increase in sex because of both flood and drought, with a significant amount likely to be unprotected, often in exchange for material benefit.

Community members reported that a far larger number of women who had been displaced and were living in accommodation and resettlement centres were becoming pregnant than usual. The reasons given were that people are now living in a concentrated area, with more venues for people to meet and less social control than there was in the more isolated islands. This breakdown of usual social practices was described in Chupanga resettlement centre as situations where '*young girls are having sex for a biscuit or 10 meticaís*' (approximately US\$0.40). In several cases the man accused of being the father would deny his role arguing that the girl had many partners or the young woman would herself be unable to name the father, whereas before displacement an arrangement for payment of "damages" by the man's father, of 100-200 meticaís would be the norm. It was also noticeable that with improved road transport, girls could get into town more easily and were potentially more exposed to sites where they were at sexual risk such as bars and a wider range of sexual partners, out of sight of the usual social constraints that they would face in a rural area .

The other increase in transactional sex after flood displacement was more explicitly transactional. In Chupanga and Caia, informants reported cases of sexual bartering in return for goods or cash between the host community who were not receiving humanitarian assistance and the displaced population. For example, communities in focus group discussions said women were '*going to fetch firewood when we know that they do not need firewood*'.²⁴

²³ The information available on STI availability from Guijá and Caia Health Centres is that STIs were increasing. However, it was not possible to get information on numbers or trends.

²⁴ After the 2001 floods, some displaced people built houses in the government-allocated resettlement areas but traveled to work on their fields. Others returned to live nearer their fields in the sites that were flooded again in 2007. The resettled communities were the host communities in 2007 and, for example, were expected to clean land for accommodation centres. The resettled communities were not entitled to aid, despite losing all their crops in the floods.

In Guijá District, the area which has suffered from drought, community members referred to a significant increase in numbers of girls 'going to town to look for work' ("*going fishing*"), which was used regularly to describe sex in exchange for goods. The girls and women that were reported to be doing this were those that were poor. Transactional sex was reported to increase when there was no food, according to informants in the district. *'Because of the drought, there are cases of girls who end up prostituting themselves, they are 15 or 16 years old, some of them already have babies'* (Female community member, Guijá) In those cases where there seemed to be an explicit intention to engage in transactional sex, the sexual partners were reported as being construction workers or truckers. *'The majority of people living with HIV are people who 'go out with' powerful people in order to get some basic goods.* (Hilário Macamo, World Relief, Guijá). *'It is hard to find someone here with economic power who has HIV/AIDS... There are infected people who go to Chókwé and have sex without condoms looking to improve their live.'* (Arlindo Mazivila, Mozambique Red Cross, Guijá).

Condom availability is important in the context of this discussion. Condoms were provided to some community volunteers (for example, according to information provided by community volunteers working with the NGO FDC and to women participating in a micro-credit project run by Project Hope in Chókwé). They were also available in the health centre during the visit undertaken in this report. However, it was not possible to find out the extent to which condoms are available within the community and, in particular, accessible and used by young women. According to community members who are part of the Union of Agro-Fishing Associations of Guijá, *'we volunteers do presentations in the community and distribute condoms and, when these are finished, we fetch more from the Health Centre.'* None of the women in the community who worked as volunteers, in FGDs for this study, referred to any condom availability except for during the awareness raising sessions that they conducted in the community.

Some of the livelihoods interventions targeted at specific groups as a poverty reduction measure in Gaza Province may have unintentionally increased women's vulnerability to HIV infection. One example encountered was micro-credit interventions for female-headed households. Women would travel for periods of up to two weeks to buy and sell goods for trading. It was acknowledged that this would probably involve an element of sexual bartering to get the best price, as well as recreational sex (sexual violence was not referred to). HIV prevention information was provided in discussions with the women but condoms were not provided.

Young men were rarely included in interventions supporting the most vulnerable. This lack of intervention also seems, by default, to be increasing their HIV vulnerability, and those of their sexual partners. Men in Gaza province have historically migrated but the patterns of migration are changing. Formerly men would be officially recruited and employed on long-term mining contracts. Now most migrants are apparently travelling across the border "*under the wire*", entering South Africa illegally and seeking informal employment or making money through crime. Adult community members mentioned that 'our sons go and end up in prison' or do poorly paid work on commercial farms, few are sending money back other than those that seem to be successfully involved in crime. *'Chókwé town at the weekend is full of stolen cars'* (Community member, Guijá). This is highly likely to increase their HIV vulnerability as well as those of their partners at home when they do return. Existing prevention campaigns based on formal migrant labour to the mines are likely to be seen as irrelevant by young men. Although this is not a directly emergency-related risk, it would be interesting to know whether there are increased numbers of young men migrating when times get tough or whether already vulnerable households have a higher (or lower) level of migration. Informants talked about the large number of men who choose to leave 'when times get hard'.

There was therefore a considerable amount of tension. The resettlement plan was a government (FRELIMO) plan so those that had not agreed to resettle are associated with RENAMO.

There was no evidence of a noticeable increase in sexual exploitation as a direct result of the emergency, for example of sex in exchange for humanitarian aid. One informant in the district hospital in Caia mentioned sexual exploitation by traditional and community leaders during distributions, but this was not repeated by others, despite explicitly asking this question. This was mentioned as a possible risk by several informants at national level. In practice it seems that this did not happen significantly, possibly because the displaced communities knew the area to which they were displaced and knew the local community. Levels of social cohesion remained relatively high and families tended not to be separated. .

Increased vulnerability of HIV-affected groups to stigma, discrimination, exclusion or violence

There were inconclusive findings about the level of Increased vulnerability of particular HIV-affected groups because of the emergency (other than in the livelihoods context, which is discussed below). 'Natural emergencies' inevitably impact worse on already poor households, a large part of whom are HIV-affected (houses with chronic illness, elderly headed or large numbers of additional children). There are already programmes to serve vulnerable groups (elderly headed households, people in home-based care, OVC) and these continued during and after the emergency in both settings. The following observations were made about groups who may potentially have been discriminated against or excluded during and after the emergency:

In general, it was felt that households who were not able to flee the floods or, for example, build houses in accommodation centres were supported by their neighbours and were not excluded from distribution of humanitarian assistance. One case was cited of a child headed household which was prevented from living within the accommodation centre; this was reported to the district social action officer who resolved the situation through discussion with the residents of the centre. Other elderly and child-headed households seem to have been accommodated within the accommodation centres.²⁵

Discrimination against people living with HIV was mentioned by several humanitarian agencies as a potential risk. However, both people living with HIV interviewed in this study and those living in resettlement centres did not identify this. This may be because the study took place at least eight months after the displacement and people's memories have forgotten some examples of discrimination. It may be that the type of direct discrimination that many acknowledged used to exist is diminishing. This was mentioned by RENSIDA informants as well as people living with HIV. They did all, however, cite examples of indirect discrimination within families in particular.

Community members who had been displaced during the floods reported that some children and elderly people had received fewer goods, with local leaders' children replacing them on the distribution lists. *'There are food distribution problems. There are orphaned or vulnerable children who are registered, but when the time comes they do not receive anything. Others who are not registered receive.. The same happens with the elderly given that they cannot get to the front of the queue to receive food and they cannot say anything. We saw this at distribution time.'* (community member, FGD, Chupanga Resettlement Centre).

One aspect of discrimination that was raised in Guijá, related to HIV, was the common accusation against older people accused of bewitching people who discovered or suspected that they had HIV. *'Now it is easy, there is adherence. Before, sick people were in denial. They did not accept our sensitisation to go to hospital, it was said that they were bewitched'* (Female participant, community FGD, Guijá). Witchcraft accusations seemed to increase the more resource-stretched that households were (and presumably therefore the more desperate to find an explanation for their sickness).²⁶

²⁵ Reported by Jeremy Hopkins, UNICEF, Protection Cluster lead.

²⁶ Vukoxa had, in response to this, developed a number of HIV educators and para-legals from their network of older people. It was suggested that these para-legals could play a useful role in any future emergency that involved displacement and where there were conflicts over property, because of their skills in legal education and conflict-resolution.

Although there was no evidence of a dramatic rise in sexual and gender-based violence directly caused by the emergency, several people talked about an increase in the number of men in accommodation centres 'who do not work and just drink'. Activists and community workers saw many women who had been beaten. Informants mentioned one woman killed by her husband with boiling water and one man beaten unconscious by a wife who was tired of being physically abused. Apart from these two examples, SGBV was not cited as a serious problem by community members and the reasons may be either because levels of SGBV were more visible to service providers once people were in less remote areas or because SGBV is seen as 'the norm' by many people and people preferred not to refer to increases in SGBV.

SGBV was not mentioned in the slow-onset areas, beyond already high tolerance of domestic violence and sexual assault in 'normal times'.

School attendance and drop out was not mentioned by any informants. It is therefore not possible to assess whether there is a long-term impact on children's access to school (and therefore lifeskills etc.)

5.1.2 Resilience

There was consistent feedback from informants in both flood-affected and drought-affected areas that children in particular are increasingly dependent on *ganho ganho* to support their family. *Ganho ganho* is piece work, very often working on other people's fields, and is almost always poorly paid, occasionally physically dangerous (carrying goods after dark in areas where there may be increased risk of sexual assault, for example) and prevents the child from attending school. A particularly risky element of children's piece work in Caia was working in or around the bars on the riverside. This area has grown up as a place for bars and sex work and, as such, is not a suitable environment for children to be working in. Earlier research in Caia showed that these children were disproportionately orphans or from very vulnerable households.²⁷ The other group that referred to *ganho ganho* as a necessary livelihoods response were people living with HIV (see section below). This trend was noted by all but did not feature in studies on longer-term livelihoods options or post-recovery plans. *'There are vulnerabilities directly caused by the emergency. In male-headed households, it is hard to see a girl carrying a sack of rice, but if the household is headed by a woman or a youth when they go out in search of a means for survival it does not matter what they bring or how...'* (Gerson Nhacale, Save the Children UK, Caia). It seems that the type of work undertaken did not change during or after the emergency, but that the amount of work undertaken increased. The information available is not gender disaggregated information but the people reporting it, both community members and NGO representatives, felt that it is predominantly boys. It will be useful to further explore the links between emergency-related vulnerability, exploitative child labour and HIV.

What is clear from both flood-affected and drought-affected communities, is that already extremely food-insecure households, including many of those that are HIV-affected, are becoming increasingly impoverished. The longer-term (post-emergency recovery) livelihoods interventions in drought-affected areas seem to be dependent on available water sources (river or construction of small rainwater catchment basins) or are based on small-scale interventions (chicken or pig rearing) that are not meeting the household needs. It was too early to assess whether post-recovery operations in the flood-affected areas were going to meet the livelihoods needs of those who are too labour-poor to benefit from the agricultural focus of the response.²⁸

²⁷ This both from assumptions made by informants (community members and local community-based workers) and previous studies conducted by SC UK in Caia in 2006.

²⁸ A number of livelihoods assessments are being conducted in the flood affected areas at present. It seems that production and local markets are healthy but there is less information on whether HIV-affected, elderly or child headed households were more adversely affected than others.

During the floods, according to the sex workers who participated in a FGD, there was an increase in numbers of sex workers arriving in Caia, the centre of the humanitarian operation. In the FGD with sex workers in Caia, they reported that many sex workers came from Beira and Quelimane (the two nearest provincial capital cities) but they were not able to estimate numbers. The sex workers who were working down by the riverside and agreed to participate in a discussion with the researcher were all from Caia. Three were aged between 17 and 19 and the other two were around 30 years old. Although most were already engaged in sex work before the floods, they said that there were many more sex workers during the emergencies who arrived from Beira, Quelimane and Chimoio. *'There were many white men and lots of money'* (Sex worker, Caia). Clients included motorists, construction workers, tourists and travellers. They said that even though there were more clients, there was more competition although they would not discuss whether this forced them to reduce condom use. Although the women who took part in the FGD reported that they did use condoms, during further discussions they appeared to have limited and conflicting knowledge about condom prices, implying that it is unlikely that they always use them. They said that there were many condoms during the emergency (although they did not say where or how these were made available) but now they have to buy them. *'Normally we do it with a condom... when the client doesn't want to use it we return the money. During the floods there were many condoms. Now we buy a box for 25 meticaís... others sell 4 condoms for 1.50 meticaís. The hospital has free condoms'* (Sex worker, Caia).

Despite an increase in numbers of sex workers specifically because of the emergency, there were no specific interventions for sex workers as part of the overall humanitarian response. The one existing project was not involved, nor consulted, during the emergency response. In discussions during the FGD with sex workers, it was apparent that the women had some knowledge about HIV transmission and means of prevention. But it was also evident that they did not always have the capacity to negotiate safe sex with their clients: *'this is our sole means of making a living... we made more money during the floods than now... I had a friend that worked with me and had a 'gonorrhoea' and was not treated well at Caia Health Centre. They kept on saying 'come back tomorrow, come back tomorrow' and she gave up and went to Quelimane... the sickness HIV exists and at any moment you can catch it.'*

5.2 On people living with HIV

5.2.1 Vulnerability

The main ways in which a rapid or slow onset emergency could increase the vulnerability of people living with HIV include: disruption in supply of treatment and care both for antiretroviral drugs and care and support of opportunistic infections including TB; reduced access to food, clean water and sanitation thus increasing exposure to infections; reduced access to condoms increasing the chances of unsafe sex for both the HIV-positive person and sexual partners; increase in stigmatisation, marginalisation or discrimination against people living with HIV. The situations in flood-affected and slow-onset areas were found to be quite different.

In the drought-affected context, the main problems identified were reduced access to food making it harder to adhere to treatment and possible difficulties in providing home based care because of a lack of access to basic resources for care and support. Provision of ARVs was not disrupted. ART is provided primarily through a local mission hospital and the district health centre, both of whom continue to function during food shortages. The possible increase in failed adherence is discussed further below.

The most commonly cited impact of drought on people living with HIV, during this study, was reduced adherence to ART and increased deaths of HIV-positive people due to lack of food. This was referred to as the number one problem by every community-level informant in Guijá. In Guijá district health centre, 285 people were registered on the ART programme, which started last year.²⁹ Almost one quarter of the total number of people registered for ART in Guijá (68 out of a total of 285) had defaulted by not coming to collect their ARVs, as they were required to do on a monthly basis. This was a higher number over the past month according to the district health team. This was also referred to by agencies providing food aid, such as Samaritan's Purse, World Relief and the Mozambican Red Cross. There are, however, other possible reasons as well for defaulting: the records of the Hospital do Camelo indicate for example that failure to adhere was for a range of reasons, with at least half the cases in October due to patients going to South Africa.

There was no reported increase in discrimination according to community members who are providing home-based care. Unfortunately, it was not possible to hold FGDs with people living with HIV in Guijá, so it cannot be assumed that this did not happen. However, there seemed to be common acceptance, from health workers providing ART, from community members and from community activists providing home based care, HIV prevention and OVC support that there had been a marked reduction in discrimination, especially now that treatment was available in the district. *'Now that there is treatment and people are getting better we can say that there is no discrimination, so much so that there are sick people who approach the volunteers and ask for assistance to get to the hospital'* (Female community member, Guijá). It was reported that now people could see their family and neighbours getting better and going back to work, they could see that HIV was not something to be feared as much as it used to be.

In flood-affected areas, the situation was very different. There was limited or no disruption of care or support because there was already an extremely low level of service provision to the displaced communities, with little or no access to ART or to home based care services. Those who were on treatment already were already living near the district centre and were not displaced, primarily because of the limited access to VCT and ART in the flood-prone areas. HIV treatment is focused on district centres such as Caia. (Numbers of people receiving ART during the floods were not available.) The total number receiving treatment in Caia district was 223 and in Marromeu 135 in July 2007 and would have been less in February 2007. Given that flooding happens in the more remote rural areas with less infrastructure, that the government is discouraging people from living in such areas and preferring them to live in settled high ground areas such as the district centre, and given the limited access to VCT in this district, it is not a surprise that at present few of the displaced population had ever had an opportunity to test for HIV or to easily access treatment.

The few displaced people who were on ART were able to continue treatment because of the efforts by health workers and activists who walked around the camps looking for them. However, it was observed by several informants that if there had been significant numbers registered on the ART programme, or receiving TB treatment, it would have been harder due to a lack of documentation that could be used for tracing.

During focus group discussions with people in the accommodation centres they reported that 'there are *many* people with chronic illness here'. Nurses in Caia and Morrromeu listed HIV-related illness in the top three causes of morbidity and mortality. However, the majority of people living with HIV in the flood-affected areas remained undiagnosed – treatment levels in the district are low. 223 people in total in Caia District by the end of August 2007 according to Ministry of Health data. Levels of denial and lack of awareness of HIV are very high.

The movement of people to concentrated areas nearer to services such as HIV testing and treatment facilities was seen by several informants, including MONASO, UNICEF and Christian

²⁹ Many people travel to Chókwè town where a mission hospital, Hospital do Carmelo, has been providing ART since 2003. In October 2007 it had over 8,500 patients on ART.

Aid, as an opportunity which was not maximised. There were general prevention campaigns conducted in the camps, but no targeted VCT mobilisation linked to referral for treatment, care and support. One padre did refer several people for testing at a mission hospital in Beira. In a focus group discussion with community members in the former accommodation, and now resettlement centre at Chupanga, people said '*there is noone with HIV here*'. However, they did acknowledge that there were 'very many' people with chronic illnesses, often ascribed to witchcraft. One FGD participant, a young man, had himself been transferred from a food for work to a vulnerable populations feeding programme because of his sickness but he denied that HIV was a problem in the local area.

There was no report of HIV transmission risks during blood transfusion or because of lack of infection control measures, although data on this was not gathered. Because displacement happened generally in an organised fashion and there was no noticeable increase in diseases requiring blood transfusion or in trauma requiring surgery, it is unlikely that there was an increased need for blood transfusion. Condoms were reported as not being available during the immediate displacement. This gap was remedied in the medium-term with both the National AIDS Control Programme and a number of humanitarian agencies providing free condom distribution through health posts and general distribution.

There was reasonable provision of water and sanitation in accommodation centres. However, this is not the case in the resettlement centres where there seem to be limited plans to provide these services.

Malaria is one of the most serious illnesses that can affect people living with HIV. Pregnant HIV-positive women are especially vulnerable and malaria increases the risk of transmission to their child. It is therefore essential that malaria prevention and early treatment is prioritised for care of people living with HIV. High levels of malaria reported in the accommodation centre health centres (over 200 cases per month in one centre). There was no mention of provision of insecticide-treated bednets to pregnant women during the emergency or to people living with HIV.³⁰

Health workers in the health centres reported that malaria, HIV-related illnesses and diarrhoeal diseases were the main causes of death. However, the levels of malaria morbidity and mortality were no greater than normal (WHO, 2007). The fact that morbidity and mortality rates were reported as having no significant change is an indication of how serious malaria already is and how limited are the existing health facilities before the emergency. Although it would be hard to provide insecticide-treated bed nets to HIV-positive people at present, given the very low numbers of people who know their status, the high levels of malaria suggest a severe impact on people living with HIV.

There was no reported discrimination or marginalisation of people living with HIV, again largely because of the low numbers of people who had ever taken a test and the high level of denial that HIV was a problem in the area. Some organisations involved in the response did report that discrimination against people living with HIV was evident in, for example, allocation of housing by assuming that shelter would not be provided to HIV-affected households.³¹ This was not reported in discussions within the community, although it is possible that more in-depth discussion would be needed to conclusively determine this. People living with HIV reported reduced stigma generally over time. They did not feel that the floods had made any significant change in either increased or decreased levels of stigma from their neighbours and families. They felt that any discrimination experienced was related to poverty than to HIV infection in itself. They reported receiving support from neighbours when first sick, but that the support slowly disappeared when it was clear that the sickness was ongoing.

³⁰ This observation is made from existing available project reports. It may have occurred and not been reported during the visit. What can however be concluded from this is that malaria prevention is not included as a core component of HIV prevention and care,

³¹ Cited in a progress report by Oxfam Intermon on their HIV and SGBV emergency response.

5.2.2 Resilience

As stated above, few people who knew their HIV status had been displaced during the floods. The HIV-positive participants were already resident in Caia town before the floods. However, many of them had lost their crops during the floods and were now having to rely quite substantially on doing *ganho ganho* because it was hard to travel to their fields and re-plant their crops. They opted to do *ganho ganho* because it provided immediate cash. This is something that needs to be monitored when considering post-recovery agricultural inputs, given that many families will have further to travel for farming than before displacement and those who are frail will find it harder to recover than others.

The livelihood options on offer for households with someone with a chronic illness were again those that were on offer to the community as a whole - small scale market gardening or livestock production. There were attempts to address the particular needs of HIV-affected households, for example projects being developed in drought-affected areas by the Lutheran World Federation and FDC. However, there were also reports from local NGOs in Guijá, such as the CVM and World Relief, about income generating income projects that were not generating any meaningful level of income at household level because of a lack of technical expertise in, for example, local market analysis. Several of the lessons learned in mainstreaming in other parts of Southern Africa are not being applied due to the limited and patchy interventions on livelihoods.

In the drought-affected areas, one livelihood option that people were taking up was migration. Many people on ART appeared to be going to South Africa, almost all with no referral letter to continue treatment there. The assumption is that these people were feeling well enough to work again. This is not strictly related to the emergency. However, there is a connection in that this failure to adhere was not being fully analysed by those providing care and support because of sometimes inaccurate assumptions about hunger.

5.3 On service provision

5.3.1 Health services

The biggest challenge for most of rural Mozambique is the overall lack of access to basic services. In particular, the flood affected communities living on the islands had few if any HIV-related or general services. As observed by several informants, the emergency could have been an opportunity to identify and get support to people living with HIV. There were no campaigns to bring in mobile VCT, for example. *'People didn't see the emergency and population movements as an opportunity to extend 'normal' HIV care'* was an observation made by MONASO who saw that there was far less transport problems during the emergency but that afterwards things went back to the pre-emergency situation. There has therefore been no significant shift in access to HIV services during the flood displacement. There was equally no reported shift away from HIV-related to other services during the displacement.

Condoms were distributed during the intervention, largely through INGOs and via health centres established in accommodation centres although no numbers were available. CNCS also provided condoms several months after the flood. A number of public information campaigns on HIV prevention were conducted. For example, Oxfam Intermon worked in partnership with local activist theatre groups to conduct HIV sensitisation. It was, however, unlikely that there were significant benefits from condom distributions, because knowledge levels were low and there was no evidence of unmet need in the absence of condoms. The one exception here is sex workers, who appreciated having free condoms, rather than having to buy them as they apparently were doing at the time of this study.

In the slow-onset emergency, there does not seem to have been any significant impact on either improvement or deterioration of HIV-related health services. As a high prevalence area, Gaza Province already has a high level of awareness and a sizeable community response. The biggest challenge is that health services are still centralised at district level. When people's household income drops because of drought, it is possible that people find it harder to access HIV-related (and other) health services because of costs to travel to the district health centre. This was cited as a problem by several informants. Red Cross and World Relief were both helping with organising joint collection of treatment to save on transport costs, for example.

5.3.2 Other basic services (education, sanitation, nutrition, etc.)

In the flood affected areas, the overall response from a range of informants who were already working in the area or who are conducting livelihoods analyses is that the response was sufficient and possibly even 'too much' for a relatively small emergency. There was no sign of increased malnutrition and possibly even a slight decrease in malnutrition, probably due to food distribution at what is traditionally the 'hungry' period. This highlights the underlying levels of poverty which require a longer term solution in this part of Mozambique (SETSAN, 2007).

Some of the water and sanitation services provided were criticised by local community members and people already working in the area before the floods. *"People do not use these new latrines because they think they will fall down them."* *"Things like female hygiene kits were distributed – people had never seen things like this before."* The total lack of access to services before the emergency, and an undoubtedly high level of service provision for the displaced population (but not the host community) led to this conclusion. The fact that there seem to be limited programmes focusing on post-emergency recovery in relation to improved infrastructure probably leads to this comment.

There was immediate disruption of education services when people were initially displaced. However, there was a very rapid response to this, with emergency education programmes being provided in the accommodation centres by humanitarian organisations such as UNICEF and Save the Children.

Markets and other economic activities were also not reported to be significantly affected (other than the loss of all crops in the flood affected areas). Markets were not affected because they occurred on the higher ground. Other activities, such as fishing, were not significantly affected. (SETSAN 2007).

6. Key findings and recommendations

6.1 Key findings related to the impact of the emergency on people living with HIV, HIV services and HIV vulnerabilities

Increased vulnerability to HIV infection

The most striking finding related to increased risk of HIV transmission is the substantial increase in transactional sex during and after the emergencies. This was evident in both flood-affected and drought-affected areas. In the case of population displacement in the flood-affected area, there was reported transactional sex between displaced and host community members. In this flood, displaced households received goods, whilst the host populations did not receive benefits although in many cases they had also lost their livelihood because they were also farming in the same flooded area.

There was also a significant level of transactional sex between local girls and women and men who were mobile – mainly truckers and construction workers. This transactional sex was reported in both sites at all times of the year, and before the emergency in the case of Caia. However, it was reported that numbers of girls and women engaging in sex at transport routes increased after the emergency or during the hungry periods in the chronic drought context.

There were reports of an increase in consensual sex, particularly amongst younger women, in accommodation centres. The changes that were reported seemed to be a greater number of sexual partners and sexual relationships that were not recognised within existing social mores, leading to a greater number of unwanted pregnancies that were not acknowledged and supported by the alleged fathers and their families. There were also concerns that improved access to and from the resettlement areas to urban centres, such as Caia, were making it easier for young women and young men to be exposed to sexual risk.

In flood-affected areas, condom use appeared low before the emergency. There were no impact assessments on levels of condom use during or after the emergency. However, a number of other factors observed during this study indicate that condom use was unlikely to have increased during the emergency. These factors include: pre-existing low levels of information about HIV; reported increases in the numbers of people presenting with STIs at health centres; unplanned pregnancies in the accommodation and resettlement centres that were reported by community members and felt to be caused by the displacement and changed social conditions in the more crowded accommodation centres.

In the flood-affected areas, the main emphasis in the emergency response was provision of prevention information during the immediate displacement through use of awareness campaigns and condom distribution. However, there was limited information prior to the emergency that could inform an effective prevention campaign (for example, local KAP studies or cultural or gendered analysis of the epidemic). There were few locally trained activists who were able to provide messages in culturally-, age- and gender-appropriate ways. Groups that were already working on HIV prevention in the flood-affected areas, by and large, did not participate in the emergency response although some youth groups and prevention activists have been supported to continue prevention programming in the recovery phase.

There were higher levels of HIV awareness in the drought-affected areas and an existing cadre of community volunteers who would be able to conduct mass prevention awareness sessions if needed in another rapid onset flood. Community members and local NGOs, however, were not aware of any emergency preparedness planning activities for displacement.

Although there was greater overall evidence of HIV prevention interventions in the drought-affected area, there appeared to be limited linkage between these groups and local livelihoods interventions. In particular, there was apparently no explicit discussion about transactional sex as a means of coping with chronic poverty and drought.³²

HIV prevention needs are insufficiently integrated into emergency preparedness planning and response. In the drought-affected area, transactional sex seems to be directly attributable to poverty and is primarily women, largely young women and girls, having sex with people at construction sites or transport stops in return for material goods. Several livelihoods interventions – designed as a response to the chronic food insecurity in the drought-affected area - appear to unintentionally be increasing women's vulnerability to HIV infection. Support to women to diversify their income through support for them to become petty traders may well be unwittingly increasing their risk of HIV infection. It is known from several studies on women traders that they have high levels of sex, both for gain and for pleasure, whilst travelling (Selvester, 2006). Such interventions

³² It was not possible to meet many groups working on HIV prevention during this study due to time limitations. Some of these linkages may, therefore, already be addressed by other groups.

did not include specific HIV prevention programming in their work and several projects visited during the study did not provide condoms.

In other cases, some groups of people who appear to have an elevated risk of HIV infection during times of heightened food insecurity. In particular, young men in the traditional migration areas that are affected by chronic drought are migrating to South Africa in a less organised way which is likely to be exposing them to HIV. Crossing the border illegally and either working illegally on commercial farms or becoming involved in informal work or crime in South Africa is likely to increase their HIV risk. No HIV prevention programmes were apparently aimed at this group of young men. Many interventions have been designed over the years for Mozambican miners, both in the sending community and in the mining hostels and communities in South Africa. There was no mention made in Guijá of HIV interventions designed for this new pattern of migration. The absence of livelihoods interventions that are providing substantial economic benefit to girls and women – either directly through safe interventions for girls and women and/or interventions for men who are contributing to household income, is continuing to provide this risk. The most recent HIV data for Gaza, with an increase from 19 to 27% over three years indicates the extreme vulnerability of the local population to HIV. Whilst HIV knowledge levels are relatively high, far higher than in the flood-affected areas, the levels of unprotected sex clearly remain high.

Levels of sexual and gender-based violence are assumed to be already high, according to existing knowledge at national level. There are few if any interventions addressing SGBV. There were no marked increases in levels of sexual exploitation or violence in either slow onset or rapid onset emergencies. However, it was obvious from discussions in the resettlement centre that people were noticing levels of violence that they did not previously notice. There was some suggestion that this was linked to increased alcohol misuse. Few of the reports on the emergency mentioned SGBV as a risk

Increased vulnerability of HIV-affected people

In both flood and drought areas, there was a reportedly large increase in piece work (*ganho ganho*) by children after the emergency. Much of this appeared to be exploitative and likely to lead to physical violence, increased risk of HIV infection and longer-term reduced life options because of school drop out. This phenomenon was not commented on nor seemed to be addressed in the humanitarian or livelihoods response in either context.

It is not known which young men in drought-affected areas are more likely to undertake risky migration, leading to limited financial gain and higher risk of imprisonment or violence. There was a suggestion that orphans were more likely to leave school earlier and feel that there was less hope in that district.

Impact on people living with HIV

In the flood affected site, it was relatively easy for people to continue ARV treatment. The few people who were already receiving treatment continued to do so after the floods. However, the general feeling from people living with HIV and local service providers is that this is largely because there were few displaced people already receiving treatment. The numbers were so small that it was possible for volunteers and health workers to go out and find those who needed treatment and care. There were concerns that this would be more difficult as numbers of people registered for treatment rise, because record keeping and systems for ensuring continuity of treatment were reported to be weak.

Field reports during the emergency consistently mentioned the difficulties of 'finding people with chronic illness'. Yet there were few linkages made by humanitarian response organisations with local home-based care programmes, despite them being an obvious potential partner for accessing people living with HIV or people with a chronic illness. There are a number of home-based care groups which MONASO and the local health care providers would know about. Vulnerable group feeding was being implemented by some NGOs, such as the Christian Council of Mozambique,

and the criteria would include the chronically ill. It is unclear why the knowledge that HBC providers had was not used by other humanitarian agencies to ensure access to people who might have needed care and support. (On several occasions, respondents stated that if people had not tested it was not possible to know if they were HIV positive, implying that this is why they had not made links with HBC). It was not possible to explore sufficiently why there was a communication gap between existing home-based care programmes and those coordinating the humanitarian response in order to identify and support people with chronic illness.³³

Malaria prevention was not seen as an important HIV-specific finding according to interviews conducted during this study. The very high level of malaria in the area during the emergency presumably affected people living with HIV, including pregnant women. No data was found to indicate whether the emergency made people living with HIV more vulnerable to malaria or more or less able to access early prevention and treatment. The absence of data on malaria and HIV itself indicates the lack of consideration of HIV-specific factors in the emergency response.

In drought-affected areas, the fact that people are not displaced means that ongoing access to treatment is not an issue. What is a serious issue is the high level of treatment drop-out which appeared to be insufficiently addressed. There is a need to explore in more detail the high levels of treatment drop out in order to find the most appropriate responses, especially to identify those which are directly attributable to food insecurity because of general drought and those which may have another cause, such as the lack of money for transport (exacerbated by poor harvests), incomplete adherence counselling or a return to (migratory) work by a person whose health is improving.

Although in general the post-emergency recovery livelihoods needs of people living with HIV will be the same as others, there was a slight increase in *ganho ganho* in Caia amongst people living with HIV. This was not reported in Guijá, although it must be noted that no discussions were held with people living with HIV. There appeared to be a predominance of 'income generation activities' that were only providing limited economic benefit in both Chókwé and Guijá. *'There is hunger because it doesn't rain... The solution is ganho ganho and people receive 20 meticais (approximately \$0.80) which is nothing. We do income generation projects... We build pig sties and give piglets to children, we sell them and buy school material.'* (Arlindo Mazivila, Cruz Vermelha de Moçambique, Guijá).

This sense that the projects were too small to make a difference were repeated by people living with HIV in Caia: *'Now that there is no work, what I do is my own fields and I work on other people's fields to make 10-20 meticais (approximately \$0.40 – 0.80) to buy food.* (Person living with HIV, Caia Health Centre). *'With the support of Food for the Hungry International (FHI) we have started projects. At the moment we have 9 guinea fowl and 5 chickens, 20 goats that have had 2 kids. We are opening a 7 hectare field for sesame and maize. We are learning sewing and dress making and have 3 sewing machine.'* (PLHA, Associação Mwatipedza, Caia). The CNCS-funded emergency response projects have an impact mitigation and it is possible that they will identify key HIV-related factors that will need to be considered in post-emergency recovery programmes. Due to delays in funding and implementation, these projects have been slow to set up and have not yet been evaluated.

Livelihoods responses and humanitarian assistance for people living with HIV and other vulnerable groups

Cyclical and regular emergencies seem to be inhibiting a sufficient focus on non-emergency HIV responses necessary to address long-term absolute poverty.

³³ Several planned interviews that would have assisted in this regard had to be postponed due to a visit from the governor and, in one case, the suspension of the project leader a couple of days earlier.

There seems to be limited focus on HIV in the post-recovery period, whilst there is an attempt to mainstream HIV into the immediate response. Consistently in the two study sites, people commented that they have been poorer since the 2001 floods because they never managed to recover their assets sufficiently. Although a more detailed longitudinal study of livelihoods would be needed to confirm the extent that this is true, and the type of household most severely affected, there are few initiatives that support the reestablishment of previous livelihoods for the most vulnerable households. In part in the flood-affected areas, longer-term recovery programmes are somewhat constrained while resettlement housing plans are not yet confirmed. However, there seems to be a consistent comment from both areas studied that there are limited post-recovery interventions compared to the emphasis on emergency preparedness and response. (It is possible that the long-term impact on livelihoods after the floods is limited – apparently some studies are being conducted in some of the flood-affected districts. However, it will be important to ensure that HIV-specific factors are included in these studies.)

What is already clear, though, is that for the regular (annual) rapid-onset emergency preparedness, there is a focus on preparedness planning and immediate response and longer-term recovery does not seem to receive the same attention. *'One thing I have noticed is that there were many NGOs during the emergency, but they did not stay after the floods to help these people establish themselves after the floods, for example building new houses, helping with irrigation systems since it has not rained since the floods'*. Father François Iphandjako Bazanga, Missão da Imaculada Conceição, Chupanga.

In general, from this brief case study, it appears that agricultural interventions have not meaningfully mainstreamed HIV prevention and impact mitigation into technically sound livelihoods initiatives that would be of benefit to the labour-poor households affected by HIV.

6.2 Specific recommendations that have emerged from 6.1

Reducing vulnerability to HIV infection

Reduction of an increase in transactional sex because of either emergency-induced poverty or displacement: Populations in emergency-prone areas need quality information that can help reduce HIV infections for men and women, boys and girls of all ages. Technical assistance could assist in introducing gender-related analysis and emergency preparedness so that there is a core group of activists able to identify and address emergency-specific social and economic changes that lead to HIV risk. This is likely to have more effective impact than immediate prevention 'campaigns' conducted by humanitarian agencies during the immediate response.

In emergency-prone contexts where displacement is likely to occur – the flood-affected areas – it is essential to make efforts to develop prevention activities before (and after) floods, especially in the more remote areas. If prevention activists are involved in rapid-onset emergency contingency planning, they will be able to identify 'hot spots' or negative trends in sexual behaviour during the emergency, for example in emergency centres for displaced people. They would be well placed to identify emerging risks, such as interventions with taxi (chapa) drivers or new drinking sites that emerge.

In drought-prone areas, such groups also play a role in monitoring any increase in transactional sex that appears to be linked to growing food insecurity and in ensuring that women and girls involved in transactional sex can access prevention support (such as condoms). They are also in a strong position to mainstream HIV risk reduction into emergency responses and longer-term livelihoods responses. SGBV forms a core part of this and requires a longer-term community-based focus in which older and younger men and women are able to discuss issues of gender violence and vulnerability.

HIV prevention campaigns and condom promotion are essential during immediate displacement. Ideally local groups should be supported to ensure that their prevention work incorporates issues of particular importance during emergencies, such as sexual and gender-based violence and issues of poverty or displacement and how these relate to sexual behaviour.

Condoms should be primarily made available through these groups and health and other emergency facilities. Such linkages are best made in ongoing emergency preparation and ensuring that 'non-emergency' HIV representatives form a core part of emergency preparedness and contingency planning in areas prone to both rapid onset and slow onset emergencies.

HIV prevention programming needs to be integrated into livelihoods programming – ensuring that livelihoods interventions do not only improve livelihoods but ensure that HIV risk is not increased.

It would be interesting to explore the migration experiences of young men and in particular see whether there is a link with ongoing poverty. For example, are orphans more likely to migrate illegally than non-orphans?. Any prevention intervention with young male migrants would need to be provided both in the districts of origin (Gaza and Inhambane Province especially) and the places where young men go, in the case of Guijá this was primarily Giyani and Tembisa in South Africa.

It is essential that there is condom access and that basic issues, such as camp safety, water and sanitation, are included in immediate humanitarian responses. With greater engagement of local HIV prevention, care and support groups (or a coordinating body such as MONASO) in emergency preparedness planning, it should be easier to ensure that these services are accessible to those living with HIV or vulnerable to HIV.³⁴

Reducing vulnerability of HIV-affected people

Reduced vulnerability for orphans and other vulnerable children: It would be useful to understand the scale and impact of *ganho ganho* being done by boys and girls after an emergency. In particular, it would be useful to understand more about what the risks might be in relation to school drop out, sexual or physical abuse, longer-term household impact and the type of child undertaking such work. Agencies providing post-recovery livelihoods support should be aware of the issues of child labour as well as adult labour and it would be useful for this issue to be introduced into the ongoing emergency contingency planning with child protection and livelihoods actors working together.

Similarly, it would be useful to understand more what the impact of a rapid-onset emergency is on the livelihood options of people living with HIV. In the event of a destruction of crops or local livelihood, are there HIV-specific factors that make it harder for them to recover assets (such as reduced capacity to travel longer distances for agriculture).

Ensuring that people living with HIV have their immediate care and support needs met during and after emergencies

In settings where people are displaced during an emergency, there is an opportunity to improve access to counselling, testing and – where necessary – treatment, care and support of people living with HIV. In a rapid onset emergency with displacement of people to more concentrated areas of population, there are opportunities to provide HIV services to people who have had limited access before. It would be possible to provide such services through community activists supported by existing health initiatives, for example the mobile HIV-related units operating in Sofala Province.

³⁴ Oxfam Intermon produced a checklist derived from existing resources that covers some of the most useful immediate questions to consider. This would have to be adapted by agency but is probably at an appropriate level in terms of length and complexity for most agencies conducting an immediate rapid response. See Annex 4.

Future contingency planning should identify home-based care interventions in emergency preparedness. Their role during displacement would be to ensure that regular supplies continue, that facilities such as water and sanitation are provided and do not adversely affect chronically sick patients. Home-based care programmes would also be in an excellent position to mobilise people for HIV counselling and testing and, where needed, enrolment in ART and PMTCT programmes.

If health care providers who are providing ART and PMTCT, and people who are receiving treatment in areas at risk of flood are included in emergency preparedness, they can assist in developing a system for continuity of care in the event of future displacement.

Malaria prevention is a priority for people living with HIV. Emergency interventions can facilitate access to malaria prevention information, insecticide treated nets and malaria care for all, and in particular to people living with HIV, especially pregnant women.

Treatment dropout should be aggressively pursued to identify individual causes in addition to lack of food, in settings where food distribution has happened over a period of years. Where necessary, ensure that agencies involved in treatment and referral consider other interventions that may be necessary, such as (cash) support for transport, improved counselling on food intake and side effects, and the need to ensure continuity of treatment even after getting well enough to travel once more for work.

Livelihoods interventions

It will be important to review the CNCS impact mitigation funded project evaluations and see whether the projects have analysed particular livelihoods needs (labour constraints, need to be based near a treatment centre, impact of earlier discrimination such as loss of land or assets after being widowed) and integrated these into the programmes.

There is a need for as great an attention to post-recovery interventions. These need to have an understanding of appropriate livelihoods responses. For example, the livelihoods interventions most appropriate for female headed, chronically sick or elderly headed households, including consideration of provision of services such as access to health care. This should include a consideration of potential increased HIV transmission risk.

There are several recent studies of mainstreaming HIV into livelihoods programmes across Southern Africa. It will be useful to apply and adapt appropriate lessons into the immediate and longer-term livelihoods recovery programmes.³⁵

7. Conclusion

This study forms part of a larger study with the objective of gaining a better understanding of the various emergency settings and their implications for HIV and AIDS. The study examines the experiences of those directly affected by HIV before, during and after the emergency and how the emergency and the response impact on their vulnerability and resilience. A number of general conclusions can be drawn from a review of rapid onset and slow onset emergencies in a high HIV prevalence setting.

The first general observation to make is that both rapid onset and slow onset emergencies pose a heightened risk of HIV transmission in particular on women, especially young women. However, this risk is not necessarily easily identified, as for example when there is significant displacement accompanied by conflict and where sexual and gender-based violence are 'visible'. The significant increase in usually unprotected sex by women and girls with a wider range of mobile men was very noticeable. This was especially so in the rapid onset areas. Whilst it is not possible to state that this

³⁵ There was little discussion of the issues raised for example in the projects reviewed in the field programmes reviewed in Drimie, 2006.

is directly linked to an increase in numbers of HIV infections, it seems very likely given the limited access to condoms, limited information about HIV prevention amongst affected women and girls and given the already known increased HIV risks on transport corridors in Mozambique. The 'hidden vulnerability' of women and girls who face a relatively minor displacement has significant implications for their HIV risk.

Another element of the study was to see whether people living with HIV faced particular challenges during the emergency that would affect their immediate and long-term ability to recover from the emergency. In the rapid-onset emergency, this did not come across as a significant factor. Although this may partly be due to the low numbers of people who were accessing HIV treatment and care before the flood, it does seem as if people on HIV treatment do not face severe harmful effects during a relatively minor displacement such as that experienced during Mozambique's 2007 floods. Where sufficient general health support can be provided (malaria prevention, emergency water and sanitation), people living with HIV are not at a greater disadvantage than other disaster-affected individuals.

Slow onset and chronic drought, on the other hand, appears to have a significant impact on the ability of people living with HIV to access and adhere to anti-retroviral therapy. There were clear indications in the drought context that people living with HIV struggled more to successfully adhere to treatment during the acute phases of the chronic drought. A combination of scarce resources to travel, other economic imperatives than attending treatment sites (seeking work) and insufficient food to adhere to ART are all factors that were felt to make it harder for people on treatment. The long-term implications of this for effective treatment clearly need to be understood in more detail and addressed in a comprehensive way in slow-onset disaster settings.

As referred to earlier, this analysis is complex because of the blurred line between slow onset natural disaster and chronic poverty. The study indicated that HIV-affected households and individuals seem to find it harder to cope with their immediate needs during a prolonged crisis situation, as compared to the non-HIV affected population, and are less likely to recover from it.

Finally, households already affected by HIV – in particular, elderly headed households and orphans – experienced greater levels of loss during the rapid onset emergency and seemed less able to return to their pre-disaster livelihoods. Both households containing a person living with HIV and those affected by HIV resorted to more short-term and less economically productive livelihoods after the emergency. A possibly higher dependence on piece work ('ganho ganho') indicates that such households have been unable to recover their assets. Whilst again this is a tentative finding, the general conclusion is that already HIV-affected households may not lose more than their neighbours but struggle to either have their immediate needs met or change their coping mechanisms in a way that will both decrease their livelihood options in the medium-term and, possibly, increase their longer-term HIV vulnerability also.

Annex 1

People interviewed

Maputo (national)

Susan Amoaten, International HIV/AIDS Alliance
Yohannes Antonyo, Regional Humanitarian Coordinator, Christian Aid
Ruth Mkhwanazi Bechtel, Program Coordinator, Oxfam GB
Remko Berkhout, Programmes Manager, Concern Worldwide
Mauricio Cysne, Country Coordinator, UNAIDS
Ana David, Coordinator, MONASO (Mozambican Network of AIDS Service Organisations)
Janet Duffield, Director, HelpAge International Mozambique
Francesca Erdelman, Head of Programmes Unit, WFP
Jeremy Hopkins, Social Protection Coordinator, UNICEF Mozambique
Lene Leonhardsen, Emergency officer, UNAIDS
Marcela Libombo, National Coordinator, SETSAN (Technical Secretariat for Food Security and Nutrition), Ministry of Agriculture
Rito António Massuanganhe, Civil Society Coordination Official, National AIDS Council
Júlio Mujojo, Executive Coordinator, RENSIDA (National Network of People Living with HIV and AIDS)
Deolinda Pacho, World Food Programme
Kerry Selvester, ANSA, consultant in food security and nutrition
Mike Tizora, Humanitarian Co-ordinator, Intermon Oxfam
Tom Wright, Director, Concern Worldwide

Districts of Chókwé and Guijá, Gaza Province

Guijá

Diniz Chavana, Clinical Director, District Health Centre, Guijá
João Mabilenhane, Project officer, Fundação para o Desenvolvimento da Comunidade (FDC), Guijá
Estácio Macamo, Project Manager, Fundação para o Desenvolvimento da Comunidade (FDC), Gaza Province
Hilário Macamo, Auxilio Mundial (World Relief), Guijá
Arlindo Mazivila, Cruz Vermelha de Moçambique - Guijá
Eduardo Nunes, Director of Services, District Directorate of Health and Social Action, Guijá
Zacarias Sebastião Mandlate, District Administrator, District of Guijá
Rudy Wiens, Food Program Manager, Samaritan's Purse
Focus group participants: União das Associações Agro-pecuárias Guijá: - Elisa Mucavele, Angelina Chongo, Saltina Chivambo, Maria Tivane, Sebastião Macamo.

Chókwé

Alberto Jossias Dodi, Programme Coordinator, Vukoxa (Humanitarian Association for Support to Sister Maria Elisa, Doctor, head of clinical care, Hospital do Carmelo, Chókwé
Gildo Mahluza, Programme Coordinator, Dores Sem Fronteira (CRIC) Centro Recreativo Infantil de Chókwé
Teresa Maholela, Officer for Community Development, Project Hope, Chókwé
Terezinha Maibasse, Community Programme Coordinator, ORAM (Associação Rural de Ajuda Adérito Mavie, District Director of Economic Activities, Chókwé
Jorge Mabay Tembe, Project Coordinator, Lutheran World Federation Gaza Project (Mútua), Chókwé
Older People)

Districts of Caia and Marromeu, Sofala Province

Caia

José Cuela António, Administrador do Distrito de Caia
Figueiredo de Araújo, Information Officer, Regional Directorate of INGC, Caia
João Caibone, World Food Programme, Beira
José Filipe, MONASO Focal Point, Caia
Isabel Gotogoto, Chefe do Sector da Mulher e Acção Social de Caia
Los Angels José, Agricultural Support Programme Officer, Food for the Hungry International (FHI), Caia
José Gabriel Júnior, Comité Ecuménico de Desenvolvimento Social (CEDES), Caia
Barroso Linda, HIV/AIDS Programme Officion, Food for the Hungry International, Caia
Chawada Vasco Machumo, Vice Presidente da Cruz Vermelha de Moçambique, Caia
Elena Medi, Health Manager, Projecto Consorcio, Caia
Gerson Nhacale, Save the Children UK, Caia
Ana Paula, Director of Services, Caia Health Centre
Emília Raiva, Health Technician, Cruz Vermelha de Moçambique, Caia

Caia health centre, focus group discussion with people living with HIV: Ana Agostinho, Santos Alberto, Lucinda António, Santos Araújo, Lurdes Benjamim, Victor Sande Blande, Zeca Candeeiro, Ivone Cegonha, Rosita Domingos, Madalena Francisco, Helena Santos Hebo, Luís José Jone, Rosa José, Rui Luís, Vale Gerente Malele, Elisa Manuel, Ana Maria Mateus, Laura Sábado, Domingos Paulo Saguata, Augusto Gonçalves Salvador, Zita Vasco

Associação Mwatipedza, Caia, focus group discussion with people living with HIV: Joana Francisco Campira, Xene Zeca Candeeiro, Luisa Domingo, Alberto Gemusse, Ana Manuel, Tina Manuel, Filipa Armando Moiseis, João Semo Mpinguiza

Stalls near the Zambezi river, Caia, focus group discussion with sex workers: Mãezinha, Sara, Albertina, Queta, Marieta (note that there surnames have not been included).

Marromeu

Father François Iphandjako Bazanga, Missão da Imaculada Conceição, Chupanga
Tomas Luís Guta, Medical Technician, Chupanga Health Centre
Luís Domingos Oliveira, Community leader, Chupanga
Emilia Mussa, Oxfam Intermon, Chupanga
Zito Mugabe, Oxfam Intermon, Chupanga
Henrique Zaba, Health Technician, Cruz Vermelha de Moçambique, Chupanga

Focus group discussion at the Chupanga Resettlement Centre (Residents and host community): Tina Alberto, Ana António, Lusta Augusto, Joaquim Cassenga, Joana Charle, Manuel Estates, José Nhacossa, Barreto Paulo

Regional (Southern Africa)

Mutinta Hambayi, World Food Programme
Kelly David, Head of Office, OCHA Regional Office for Southern Africa
Sonsoles Ruedes, World Food Programme
Maren Lieberun, Regional HIV/AIDS Adviser, Oxfam GB
Mumtaz Osman, Regional Humanitarian Adviser, UNAIDS Regional Support Team, East and Southern Africa

Annex 2

In-depth and focus group discussion guides

1.0 Contexto

Os países seleccionados para os estudos de caso foram escolhidos com base em critérios diversos; incluindo o tipo de emergência, a taxa de prevalência e a localização geográfica:

- Moçambique – cheias (Caia), seca prolongada (Guija)
- Kenya –seca no Norte
- Haiti – ciclones e conflito prolongada
- República da África Central - conflito no Norte
- Sri Lanka – tsunami; talvez vai ligar com conflito, mas a UNHCR está a assessorar a situação das pessoas deslocadas, pelo que não terá enfoque?.

O enfoque central desta consultoria é o *impacto ao nível dos agregados familiares; qual é a dinâmica entre o HIV e a emergência e quais são as vulnerabilidades criadas.*

2.0 Perfil do país

Esta informação pode ser obtida de uma combinação de fontes secundárias e das entrevistas com informantes chave. Há, conseqüentemente, provavelmente alguns aspectos que cruzam entre as fontes secundárias e dos informantes chave; isto pode ser usado para 'triangular' a informação.

Emergência:

- Qual é a emergência (tipo, frequência, tamanho)?
- Quais foram as conseqüências da emergência? Que tipo de deslocação havia? Quais são as formas de deslocação? (p.e. género, crianças separadas, perda de terras)
- Está a acontecer por quanto tempo? É repentino, retornado, passado, actual ou simultâneo?
- Que tipo de danos criou p.e. a infra-estrutura existente, a serviços de saúde, a agricultura, a animais domésticos, a outros meios de subsistência?
- No caso de seca prolongada, qual é a sobreposição entre a assistência humanitária e intervenções de alívio à pobreza/ intervenções económicas e de meios de sobrevivência (da ponto de vista dos indivíduos e dos agregados familiares)?
- Qual é a forma da resposta? Que tipo de organização está a fazer o quê, como, quando, para quanto tempo (ONGI, OBC, governo etc) também veja em baixo.

Epidemia do HIV:

- Qual é a prevalência nacional? Diferenças rural-urbanas, outras diferenças? Onde vem esta informação (vigilância, data, etc.) Qual é a taxa de prevalência nas zonas afectadas?
- Quais eram os grupos vulneráveis antes da emergência? Dados de base pre-emergência das taxas de prevalência vulnerabilidades específicas, uso de preservativos, etc.?
- Como foi a situação antes da emergência? (política nacional, infra-estrutura, etc.). Que serviços de HIV/SIDA haviam antes da emergência? Havia redes das PVHS, etc.? Programas de cuidados domiciliários? GATV? TARV?
- Como foi a resposta à emergência em relação ao HIV/SIDA? Prevenção, cuidados, tratamento O HIV/SIDA foi tomado em consideração nos planos de resposta?

Outros factores relacionados com a susceptibilidade e vulnerabilidade:

- Que tipo de informação (análise, fundos para programação, etc) havia em relação aos aspectos de género (informação sobre quem cultiva a terra, quem tem direitos sobre a terra etc.)

- Houve algum aumento da violência sexual e baseada em género como resultado da emergência?
- Qual é a situação (antes, durante e depois da emergência) da protecção da criança? Há organizações que prestam serviços nas áreas de prevenção do abuso sexual ou tráfico sexual com as crianças?

3.0 Entrevistas com organizações envolvidas na resposta da emergência e pessoas afectadas pela emergência

Estas são as perguntas para nos guiar, mas é importante ter flexibilidade e deixar o entrevistado falar a vontade.

Entrevistas de fundo (IDIs) com instituições do governo ONGs/ONGIs/ que trabalham nos programas gerais do HIV/SIDA

- Que tipo de projecto/programa/serviços em HIV/SIDA é que abastecem? Onde? Qual é/são o(s) grupo(s) alvo(s)? Quanta informação em HIV é disponível em geral?
- Onde, se for o caso, obtém informação sobre as actividades similares ou complementares feitas por outras na mesma zona? Quem tem a responsabilidade para a coordenação e como está a funcionar?
- Como é que descreve os níveis de estigma e discriminação contra as pessoas afectadas por HIV antes da emergência? Na sua observação, a estigmatização criou um impacto sobre a resposta da emergência para as PVS? Se sim, de que forma?
- O que fez a sua organização / como é que respondia durante a emergência, logo depois e depois dum tempo? Será possível preparar-se antes? (Se a organização não respondeu ou não mudou das actividades, porquê?)
- Quando e de que maneira a situação de emergência necessitava de uma resposta sobre o HIV/SIDA que é diferente às intervenções normais?
- Como adaptou aos vossos programas? Mudou-se o enfoque? Foi impossível fazer as actividades regulares?
- Depois da emergência (no caso de [rapid onset]) voltou a fazer as actividades anteriores? Se não, porquê, p.e. a população deslocou-se ou infra-estrutura destruída? Ou porque a emergência provocou novas prioridades? O que é que influenciou a tomar essas decisões e o que fazer?
- Tinha que mudar o grupo alvo durante a resposta emergência?
- Havia deslocação? Que tipo? (interno, trans-fronteira? Qual foi o impacto nesses serviços prestados, nos meios de sobrevivência, nas zonas onde os deslocados chegavam, etc.?)
- Qual foi o diferente impacto nos diferentes grupos de afectados? Incluindo homens, mulheres, crianças, velhos, pessoas com as categorias específicas p.e. trabalhadores de sexo, camionistas, pescadores etc.)
- Há vulnerabilidades específicas para os órfãos e crianças vulneráveis por causa da emergência? (P.e. ha falha de prestação de cuidados, acesso a escola etc.)? Houve um impacto sobre as suas estratégias de sobrevivência ? Que impacto, se tiver, na sua susceptibilidade a infecção com HIV?)
- A emergência / deslocação provocou um aumento na violência sexual e baseada em género?
- Houve migração económica por causa da emergência? Houve migração rural-urbana por causa da emergência? Se sim, qual foi/ é o impacto nas vulnerabilidades e serviços relacionados com o HIV?
- Havia novos grupos de pessoas que têm vulnerabilidades aumentadas por causa da emergência?
- Se estava a fazer programas de sensibilização/educação, como ficavam afectados?
- Se estava a prestar serviços de prevenção, (preservativos, tratamento ITS, etc.) como ficavam afectados? Como adaptou os serviços?
- Que serviços de HIV/SIDA haviam antes da emergência?

- Havia uma taxa elevada nos serviços de saúde por causa da emergência? Se sim, resultou em afectar os serviços de HIV/SIDA?
- Se estava a fornecer TARV, como foi afectado o fornecimento de medicamentos? O que é que aconteceu com as pessoas a receber tratamento? Como foi afectada a sua aderência? Normalizaram a situação agora, e se sim o que lhes ajudou?
- Como foi afectado o serviço de aconselhamento e testagem? Se interrompidos, quando começaram outra vez?
- Como foi afectado o serviço de cuidados domiciliários?

Entrevistas de fundo (IDIs) com instituições do governo ONGs/ONGIs/ que trabalham na resposta à emergência

- Em que consistiu a resposta da emergência para a sua organização? Quando começou, durou quanto tempo, quem estava envolvido?
- Qual foi o enfoque prioritário para a sua resposta à emergência?
- Incluiu o HIV dentro da sua resposta à emergência? Se sim, como? Se não, porquê?
- (No caso de [cluster approach]) Havia outras organizações que introduziram elementos de VIH na coordenação ou na resposta?
- Havia deslocação? Que tipo? (interno, trans-fronteira? Qual é que foi o impacto nos serviços prestados, nos meios de sobrevivência, nas zonas onde os deslocados chegavam, etc.?)
- Como é que foi priorizado o HIV dentro da resposta emergência? Prevenção, TARV, preservativos, cuidados domiciliários etc. Houve acções específicas para PVS?
- Havia outros sectores (distribuição de comida, alojamento, protecção da criança, distribuição de ferramentas etc.) que tomavam conta do HIV/SIDA? (P.e. alvear assistência nutricional aos doentes crónicos, adaptação à rações de comida – suplementos nutricionais, intervenções agrícolas com impacto especificamente relacionado com VIH/SIDA p.e. jardins domésticos).
- Quais eram ou foram os grupos alvos durante a resposta? Incluiu populações mais vulneráveis a contrair HIV p.e. trabalhadores de sexo, jovens?
- Qual é que foi o diferente impacto nos diferentes grupos de afectados? Incluindo homens, mulheres, crianças, velhos, pessoas com as categorias específicas p.e. trabalhadores de sexo, camionistas, pescadores etc.)
- Há vulnerabilidades específicas para os órfãos e crianças vulneráveis por causa da emergência? (P.e. ha falha de prestação de cuidados, acesso a escola etc.)? Houve um impacto sobre as suas estratégias de sobrevivência [coping strategies]? Que impacto, se tiver, na sua susceptibilidade a infecção com o HIV?
- Houve novas vulnerabilidades a aparecer por causa da emergência (p.e. exploração sexual por trabalhadores humanitárias, camionistas etc.)?
- Houve um aumento em violência sexual e baseada no género? Havia planos preparados a oferecer cuidados e apoio aos homens, mulheres e crianças afectados por violência sexual e baseada no género?

Entrevistas de fundo IDIs com PVS (incluindo as que estão em tratamento) afectadas pela emergência:

- (NB, estas perguntas nao sao apropriadas em alguns casos. Nesses casos, as perguntas tem que ser explicados numa forma mais sensível através das experiências do grupo em apoiar access ao tratamento, por exemplo).
- (A quanto tempo está a viver com o HIV? A quanto tempo está a receber o TARV?
- O que está a fazer neste momento como meio de sobrevivência? De que forma o HIV teve um impacto na sua vida como uma pessoa positiva? (Para os que estão afiliados em associações, qual é a função principal em estar numa associação de PVHIV?) Investigue perguntas de estigma se possível e se levantado como um desafio).

- Como ficou afectado pela emergência? (Meio de sobrevivência, saúde, segurança, etc. O que estava a fazer antes da emergência? Terão os seus meios/padrão de vida voltado ao que era previamente? Como mudou?
- Havia discriminação ou violência antes da emergência? De quem? Mudou depois da emergência?
- Como ficou afectada a sua família, filhos, esposo/a, etc. pela emergência?
- Que tipo de cuidados de saúde estava a receber antes da emergência? Como mudou/foi afectado pela emergência? O que estava a fazer agora para receber cuidados de saúde?
- (se a receber TARV) Como foi afectado o seu acesso ao TARV pela emergência? Quais eram as estratégias que usava para ultrapassar dificuldades em aceder o TARV?
- Qual era a principal fonte de comida antes da emergência? Recebeu apoio nutricional antes da emergência? Conseguiu obter comida suficiente durante a emergência? Tem necessidades particulares por causa do HIV, e conseguiu satisfazer essas necessidades durante a emergência?
- Houve um impacto no acesso a outros serviços essenciais que estava a receber antes da emergência? Educação, saneamento, etc. Como foram afectados pela emergência?
- Como foi o tratamento das organizações a prestar apoio durante a emergência às pessoas HIV positivas?
- Que serviços de saúde foram oferecidos durante a resposta emergência? Foram eficazes?
- Sofreu o estigma e discriminação antes da emergência? Foi afectado pela emergência?
- Foi possível aceder os preservativos antes, durante e depois da emergência? Se sim, onde? Se não, o que é que acha é a causa?
- Houve qualquer sensibilização sobre prevenção do HIV às populações afectadas pela emergência?
- Na sua opinião, acha que o risco de ser infectado por HIV é maior numa situação de emergência que normal? Porque? Porque não?

Entrevistas de fundo IDIs com membros dos agregados familiares afectados por HIV (COV, líderes comunitários, cuidadores etc.) – As seguintes são algumas perguntas amplas que teriam que ser feitas de propósito para pessoas específicas:

- Como foram afectados pela emergência (você, comunidade etc.)? (Meio de sobrevivência, saúde, segurança, etc. O que estava a fazer antes da emergência? Terão os seus meios/padrão de vida voltado ao que era previamente? Como mudou?
- Como foram as PVS / pessoas afectadas por HIV afectadas pela emergência?
- Sofreram o estigma e discriminação antes da emergência? Foi afectado pela emergência?
- Que cuidados de saúde a PVHIV vivendo com você/recebia com/recebendo na comunidade /acesso antes do emergência? Como é que isto mudou/ foi afectado pelo emergência? Que estratégias eles usam agora?
- O que é específico (relacionado com HIV e geral) vulnerabilidades resultados da emergência para órfãos e outras crianças vulneráveis?
- Que vulnerabilidade específica resultou da emergência para mulheres?
- Que outros serviços básicos acediam/recebiam antes da emergência? Educação, saneamento, suplemento alimentar, etc. Como isto foi afectado pelo emergência?
- Foi possível ter acesso aos preservativos antes, durante e depois da emergência? Se sim, onde? Se não, o que é que acha que é a causa?
- Houve qualquer sensibilização sobre prevenção do HIV às populações afectadas pela emergência?
- Na sua opinião, acha que o risco de ser infectado por HIV é maior numa situação de emergência que normal? Porque? Porque não?

Entrevistas de fundo IDIs/FGDs com trabalhadores de sexo afectados pela emergência³⁶:

- Onde executa o seu trabalho? ha quanto tempo desenvolve este trabalho? quem São os seus clientes? este É o seu principal meio de sustento/vida?
- Estão cientes do HIV/SIDA? O que sabem sobre a prevenção, transmissão e tratamento do HIV/SIDA?
- Como foram afectados pelo emergência? Seus clientes mudaram? Como foi afectada a sua segurança? Como você enfrentou/suas estratégias de sobrevivência? As suas estratégias de sustento/meios de vida mudaram como resultado da emergência?
- Encarou violência dos clientes antes do emergência? A situação mudou desde a emergência??
- Usava preservativos com os seus clientes antes da emergência? Usavam preservativos durante? Depois?
- Que cuidados de saúde recebiam/tinham acesso antes da emergência? Como isto mudou/ sido afectado pela emergência? que estratégias estão a usar agora?
- Que outros serviços básicos tinham acesso/recebiam antes da emergência? educação, saneamento, suplemento alimentar, etc. Como isto foi afectado pela emergência?
- Se quisesse, poderias obter preservativos durante e depois da situação de emergência? Se sim onde? Se não, por quê pensa isso é o caso?
- Como diferentes grupos de pessoas foram afectados pelo emergência?
- Quem pensa que tornou-se vulnerável como resultado da emergência? Porquê? Vulnerável a quê? Quem é o mais vulnerável? (para FGDs)
- Em sua opinião, você pensa que o risco de ficar infectado pelo HIV é maior em situações de emergência que em situação normal? Porquê? Por quê não?

³⁶ Dado o facto de que os trabalhadores de sexo encontram-se em todos países e sua centralidade como potenciais vectores para a transmissão do HIV é largamente aceite, um set de guiao de perguntas foi desenvolvido para eles. É possível, entretanto, que especificos grupos vulneráveis terão que ser entrevistados uma vez o contexto do pais se torne mais transparente

Annex 3

Literature review

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Annex 4

Sample HIV prevention and support checklist for use in an immediate response – developed by Oxfam Intermon and Oxfam GB in collaboration with Concern Worldwide

Human resources:

Ensure that in all inductions the following points are covered:

- Name and cell phone number of HIV/PSEA focal point
- Explain the role of HIV/PSEA focal point
- Sexual conduct guidelines are known, understood, signed and available to the person
- How to report SEA issues
- Availability of PEP and how to access it
- Condom availability and how to access them
- Read and have always on hand supplementary material on PSEA (see annex 1)
- Refer to line manager in explaining action plan on PSEA/HIV integration, his/her role and responsibility in implementing the plan

General hand:

- Ensure compound is clean of disposable material including condoms, sharp material and other potential sources of HIV contamination
- Ensure all posters on HIV/PSEA are in place at all times
- Ensure condoms, information leaflets are always available in latrines

Logistics:

- Ensure car and truck drivers always have condoms in the car
- Ensure car and truck drivers understand PSEA issues and sexual conduct guidelines
- Make programs avoiding car/truck drivers driving alone
- Have an evacuation plan to the nearest health facility with PEP available and use Oxfam cars in the event an urgent evacuation is required

Engineers:

- Be ready to provide extra water to vulnerable families and those living with HIV and AIDS
- Provide technical solutions that ensure proper latrine use for sick people (ex.: handles in latrines, room for caretaker + sick person,...)
- Provide technical solutions for bathing and hand washing of sick people at home
- Ensure safe waste disposal in PLWA houses
- Ensure safe disposal of sharps and contaminated material in health centres
- Ensure latrine, washing facilities and water points are located near houses of vulnerable people / PLWA
- Be ready to build family latrines on top of community latrines for families caring for a sick person.

Guards:

- Report any unusual movement of people in the compound especially at night taking into consideration the risk of SEA.
- Report to manager any movement in the warehouse out of working hours

Public health promoters:

- Map and localise vulnerable families (single parent headed households, child headed households, elder headed household, households caring for a chronically sick person)
- Train community volunteers in the importance of observing hygienic procedures in PLWA care
- Allow community volunteers extra time to visit PLWA houses and check if hygienic procedures are followed and how Oxfam can help in facilitating their observation

- Make linkages between vulnerable households and available, regular support services existing in the community
- Ensure identified households have adequate access to water, waste disposal, washing facilities and latrines.
- Train community health workers in PSEA reporting
- Train community health workers in spreading community rights and entitlements during the emergency, as well as ways of reporting SEA or aggression to those rights
- Ensure latrines and washing facilities are lit at night and those set apart from the population have a guard to avoid sexual assaults.
- Run community awareness sessions (serialized posters and cross fire)
- Link with and hire local theatre group to perform plays in IDP camps