

Review of International Federation of Red Cross and Red Crescent Societies (IFRC) material on HIV and AIDS and sudden-onset emergencies

April 2008

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* Disclaimer: The views presented in this paper are those of the authors
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Contents

List of Acronyms	iii
Executive summary.....	iv
1. Background.....	1
1.1 Methodology.....	1
1.2 Limitations	1
1.3 Structure of report	2
2. IFRC's response to HIV	2
2.1 HIV policy	2
2.2 Water/Sanitation policy and HIV.....	4
3. Challenges.....	5
3.1 Limited information collection on HIV	5
3.2 Short time span of response	6
3.3 Increased role of National Societies.....	6
3.4 Limited cooperation among HIV and humanitarian actors	6
3.5 HIV is not a priority in emergency response.....	6
4. Specific findings from the field	7
4.1 Study on Asian Tsunami by ANP+	7
4.2 Uganda 2007 Floods.....	10
5. Conclusions	11
6. Persons contacted/interviewed:.....	13
7. Documents reviewed	15

List of Acronyms

ANP+	The Asian Network of People Living with HIV/AIDS
ART	Anti-retroviral therapy
ARV	Anti-retroviral therapy, used inter-changeably with ART
Cluster approach	Humanitarian response system of the United Nations, designed to ensure coordination among UN agencies, joint programming, information sharing, knowledge sharing on technical and policy issues, joint formulation of sectoral/thematic strategies, promote implementation synergies by combining support and common services. See www.humanitarianreform.org
GNP+	The Global Network of People Living with HIV/AIDS
HBC	Home based care
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organizations for Migration
MISP	Minimum Initial Services Package
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
ODI	Overseas Development Institute
PEP	Post exposure prophylaxis
PLHIV	Persons living with HIV (there is no differentiation with persons living with AIDS in this report, as the data was not disaggregated)
SGBV	Sexual and gender based violence
STI	Sexually transmitted infection
UNAIDS	The United Nations Joint Programme on HIV/AIDS
URCS	Uganda Red Cross Society
VCA	Vulnerability and capacity assessment
VCT	Voluntary counselling and testing
VHT	Village health teams
WFP	World Food Programme

Executive summary

IFRC is currently scaling up its HIV response through its strengthening of national society HIV programs, and its regional and global HIV programs. However, IFRC experiences the same challenges as other organizations in mainstreaming HIV into its work and disaster response. On the whole, HIV is not integrated into disaster work. In practice, this means that information surrounding HIV in a disaster is not consistently collected; HIV is not integrated into assessments for appeals and vulnerability impact assessments; and there is limited cooperation among HIV program staff and humanitarian responders. This seems to be largely due to the view that addressing HIV is not a priority in a disaster because it is not recognized as an immediate, life-saving intervention.

Some respondents commented on the complete lack of preparedness for a disaster in certain national societies. This lack of overall preparedness adds to the inability to address HIV specifically. Most of the HIV response in a sudden-onset disaster is focused on prevention, and specifically dissemination of education materials. This may be due to the short timeframe of a response, and the inability to follow up (thereby discouraging more long-term responses). The prevention program of the Federation is also more developed and has been around for a longer time period than the newer programs and policies on treatment and care.

For the purposes of this review, that meant that documentation and assessments that address HIV in sudden onset disasters and the impacts of sudden-onset disasters on persons living with HIV or the increased risk of transmission, were hard to obtain. This may be due to the fact that they do not exist within the organization, or that they exist in such a limited quantity that they were not uncovered during the time frame of this review.

The sectors of water/sanitation and shelter both showed sensitivity to needs of persons living with HIV. IFRC has a water/sanitation policy on HIV. According to the policy, the Federation endeavors to increase the availability to antiretroviral therapy (ARV) to PLHIV “who are the most vulnerable,” and promote increased access to safe water through its network of home base care projects. The pilot project associated with the policy is designed for implementation via home based care providers in Kenya, not during an emergency situation. In fact, it has been disrupted by the recent post-election violence in Kenya. Generally, though, persons living with HIV are identified as a vulnerable group and dealt with as such in an emergency. Several of those interviewed talked about the difference between emergency and recovery phase, and the inability to respond to HIV in the emergency phase. Some mentioned as well the lack of health personnel which limits the ability to incorporate HIV.

In Southern Africa, IFRC is implementing a five year regional AIDS program, with a focus on community based programming. Some respondents noted that flooding is getting worse each year and, given the high prevalence rates, incorporating HIV in the response is vital. The lack of baseline data with which to measure impacts presents a problem. In the case of Uganda, for example, DFID funded the collection of baseline data in IDP camps in the north of the country in 2006. This data could be used to compare to data after the 2007 flooding. The Ugandan Red Cross did share impressions of the impact on HIV of the floods in eastern Uganda in September 2007, as well as OCHA’s lessons learnt of 2008, but this did not include any data collection that could be compared to the baseline.

IFRC funded one report on the impact of the 2004 Tsunami on persons living with HIV in four countries in Asia. The report looked at the immediate response, the response just after the crisis and the response a little more than one year later. The report found both positive and negative impacts on persons living with HIV, namely:

- The majority of persons interviewed became aware of their status **as a result of the Tsunami** and were able to access care;
- Access to antiretroviral therapy (ART) remained fairly constant, while employment levels dropped;
- Stigma and discrimination remained a key issue for persons living with HIV, and had especially negative impacts on communities unprepared for positive diagnoses.

1. Background

The Overseas Development Institute (ODI), in partnership with the World Food Programme (WFP) and supported by The United Nations Joint Programme on HIV/AIDS (UNAIDS), is in the process of carrying out a study on HIV and emergencies, which aims to collect and analyse information on different types of emergencies and their specific impact on the epidemic and HIV/AIDS-related services.

The first phase, which has now been completed, involved a literature review and had 3 inter-related aims: 1) to review existing literature on HIV and emergencies; 2) to develop a conceptual framework for thinking about HIV in emergencies situations; and 3) to identify gaps in the literature in preparation for the country case studies. The second phase, which is still ongoing, involves 5 country case studies focusing on different kinds of emergencies including sudden-onset natural disasters, slow-onset natural disaster and conflict/post-conflict. Selected countries include: Haiti, Sri-Lanka, Mozambique, Central African Republic and Kenya.

At a consultation meeting following phase one, the impact of sudden-onset disasters on PLHIV and HIV-related services was identified as a significant gap in existing knowledge of HIV and AIDS in emergencies. The aim of this review is to try to fill this gap by reviewing and documenting the existing evidence, literature and knowledge of two of the leading organisations in the field: IFRC and International Organization for Migration (IOM). The overall goal is to contribute to the broader ODI study, and to the development of a conceptual framework for understanding and responding to HIV and AIDS in emergencies.

1.1 Methodology

The research was assisted by a focal point in the organization, Nichole McGarry, via whom initial inquiries and requests for information were made. A series of interviews with Geneva-based staff were carried out during early March 2008, leading to contacts and inquiries in National societies. Background data and relevant reports, evaluations, and findings were passed to the researcher. A complete list of those reports can be found at the end of this report. The researcher also reviewed the literature review and some of the draft country reports in order to obtain further insights into the gaps in information, the focus of the country case studies as well as findings from the case studies.

1.2 Limitations

The data and discussions were limited to a short time frame, and it is clear that more data may emerge over time that needs to be included. The information we are seeking is quite specific, and making the links between relevant data and HIV requires either specific prompting or more knowledge of HIV than lies with someone tasked with focusing on disasters/emergency relief/other functions. In conclusion, more information may exist that can shed light on the impacts of natural disasters on HIV, but it is dependent on finding staff that can make the specific connection and recall a report that contains the data. Those staff persons may not have been reached in this short study.

An “evaluation” mindset may have limited the responses of those interviewed. The natural reaction of the respondents was to defend the IFRC response. Although the researcher tried to make very clear that this inquiry is a search for background information and evidence and not an institutional evaluation, there was a natural tendency to assume that the researcher was looking to evaluate the response of the IFRC. This led quite often to the reaction that “we should do more, we know

HIV is important.” The quest for data required moving beyond this mindset, which was sometimes difficult.

In cases where the search for information was clear, the researcher was often directed to non-governmental organizations (NGOs), Office for the Coordination of Humanitarian Affairs (OCHA) or UNAIDS for more information, with respondents noting that IFRC is not collecting this information, or that disasters require “immediate life-saving interventions.” Addressing HIV was not considered a priority life-saving intervention. In cases where additional information from other sources was immediately supplied, it has been included. However, enlarging the scope of the research to carry out the same methodology within OCHA or other organizations is beyond the scope of this work. It may be worthwhile, however, to carry out the same methodology focused on OCHA and a couple of key international NGOs at a later stage.

As noted above, the quantity and quality of the research did not allow for drawing conclusive statements. Therefore, the impressions and assessments are presented and summarized separately, noting different themes. More research and in-depth interviews are needed to authoritatively make statements on HIV vulnerability changes in the sudden onset disasters discussed here.

1.3 Structure of report

This summary report is divided into five main sections. The first section provides an overview of the work, its methodology and limitations. The second section summarizes information learned about IFRC’s response to HIV, based on the information obtained during this research. This is not an exhaustive discussion of IFRC’s HIV response, but aims to give an overview of the Federation’s policy. It also recounts information obtained in response to queries about how HIV is handled in disasters. The third section discusses the challenges of including HIV in disaster response. Finally, the fourth section examines research specific to HIV in a sudden onset disaster. This section is guided by available findings, therefore each assessment is summarized. There is such sparse information that drawing general conclusions is a stretch; hence, the research information is summarized by report, and general themes are noted in the concluding remarks.¹

2. IFRC’s response to HIV

This section gives a brief overview of IFRC’s policy on HIV today and its evolution. The information is provided to set the background and present challenges that IFRC staff have encountered and shared with the researcher as regards HIV responses in sudden onset disasters.

2.1 HIV policy

IFRC has drastically scaled up its HIV response in the last seven years, moving from limited HIV programming since the mid-1980s, to work focused on prevention in the late 1990s, to a Federation-wide endeavour to standardize and scale up national societies² HIV programs.

IFRC appointed a Special Representative on HIV two years ago in order to increase mainstreaming within IFRC and profile around the Federation’s HIV work, including fundraising and representing the Global Alliance, IFRC’s strategy for HIV. While great strides have been made in

¹ Please see the synthesis report for general themes based on both IFRC and IOM research findings.

² A National Society of the International Federation of the Red Cross and Red Crescent Societies is the local Red Cross or Red Crescent in a country.

scaling up the Federation's work in HIV, it has been described as "really in its early stages." The policy dating from 2002 was developed in a start-up phase and the program has developed rapidly since then. While there were some national society HIV programs in the early 1990s, the attention of the Federation to HIV has really only come in the last eight years. HIV is now considered "a bit of a flagship program" and has organizational commitment. Most National societies have some HIV response, and the HIV focus has been on developing a standard program. This means developing appropriate basic systems for national societies, such as volunteer databases and financial systems. The focus is building basic capacity that did not exist previously in order to prepare for scale up the response to HIV and AIDS.

HIV versus disasters?

The Red Cross and Red Crescent HIV and AIDS Global Alliance includes the Global Programme, regional programmes, and country programmes. The Global strategy has three main objectives:

1. Preventing further HIV infection
2. Expanding care, treatment and support
3. Reducing stigma and discrimination

The Southern Africa regional program³ (2006-2010), called Rising to the Challenge, is a pilot program that aims to reach:

1. 10 of 20 percent of people living with HIV and AIDS and estimated to be in need of care and support;
2. 10 percent of the orphans and other children made vulnerable by HIV and AIDS;
3. and 10 percent of the general population targeted for prevention

There are different suggestions as to why HIV lost its focus within the Federation in the 1990s, but one of the reasons implied was competition with disasters, rather than integration. The tendency to see the priority as mutually exclusive rather than inter-linked remains an issue, as evidenced in the 2005 evaluation report:

In the late 1980s and beginning of the 1990s a large amount of excellent material was produced by the secretariat in order to assist National Societies in responding to the pandemic. Unfortunately, the commitment towards HIV/AIDS faded in the second half of the 1990s. Only a very few visionary National Societies remained committed to HIV/AIDS programmes. To explore the reason for this decline in commitment is beyond this evaluation but it coincided with one of the greatest relief operations – the Great Lakes operation⁴.

And as a reason for decline in commitment, Secretariat staff cited the 2004 Tsunami as one diversion from HIV. (Most recently, the 2004 Tsunami diverted attention from the fight against HIV/AIDS)⁵.

This seeming competition between HIV and disasters is also relevant for current policy. Even where HIV is a focus, it is not necessarily linked with disaster response. This may be in part due to the focus on increasing general capacity of the national societies. In Southern Africa, it was even implied that HIV was kept separate from disaster response until the capacity of the HIV unit was deemed adequate or advanced enough to engage in emergencies.

There is now renewed organizational commitment to HIV and almost all national societies have some HIV programming. Keeping in mind that all Federation responses are implemented in

³ The Southern African regional program works in Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

⁴ IFRC, *8000 Everyday, Evaluation of the HIV/AIDS Global Program 2002-2005*, 2005, p. 8.

⁵ *Ibid.*, p.15.

coordination and in support of the national program, the challenge now for IFRC is to understand how HIV fits into other areas of core work, such as disaster response.⁶

The Federation has a strategic alliance with The Global Network of People Living with HIV/AIDS (GNP+), and subsequently funded the only study found directly linked with assessing impacts of the Tsunami with HIV affected persons and households. See section 4.1 below.

2.2 Water/Sanitation policy and HIV

In recognizing a need for clearer thinking on disaster/chronic situations in terms of water/sanitation issues, IFRC developed a Point of View (policy guidance) which outlines their stance on water/sanitation and HIV. The policy recognizes that in areas with a chronic lack of adequate water and sanitation, PLHIV are more vulnerable to impacts. Lack of access to clean water and basic sanitation is especially dangerous for PLHIV as they have reduced immunity to water-borne illnesses. Chronic drought conditions, such as those in southern Africa, can compound the vulnerabilities and effects of a lack of clean water and poor hygienic conditions by increasing water-borne illness and decreasing already scarce water supplies.⁷

For HIV and water/sanitation, it is important to seek out “low-key, low-tech” approaches. The introduction of these methods is also an opportunity to target the chronically vulnerable (including PLHIV). According to a presentation developed by IFRC on trends in disaster response,⁸ disasters are increasingly climate-related, more people are encouraged not to go into camps due to the short time frame of the emergencies, so home-based solutions are needed. These include “point of use” treatment at the river or tap, such as chlorine tablets for purification and clarification (disinfection and flocculation). These are localized solutions, as opposed to water treatment that is controlled in a camp or resettlement site, where one water source is treated providing clean water in a controlled physical proximity.

Western Kenya home based care pilot in water/sanitation

While still unpublished and not directly focused on acute situations, IFRC is undertaking a pilot study in Western Kenya to supply water/sanitation through home based care (HBC) programs – to give low technology household water treatment (i.e. PURE). The idea is to promote water treatment with anti-retroviral therapy (ART), and use home based care clients as the vehicle. While the target here was a chronic situation, this intervention could be used in an acute situation. As a next step, field guidelines will be produced to promote household water treatment generally and to target PLHIV.

Recent strife has delayed the project. The results are as yet unpublished, but the preliminary conclusions are:

1. Targeting PLHIV alone is impossible; the entire community must be targeted. The Kenyan Red Cross noted that, because water services were unavailable to all, it was impossible to single out HIV-affected households. Therefore, entire districts were targeted. Stigma and discrimination would increase if PLHIV were targeted, and there was some expectation that it might become desirable to be identified as HIV+.
2. Using HBC as a means of dissemination of the purification systems worked reasonably well in accessing the community.

⁶ Based on interview with Bernard Gardiner, Unit Manager, HIV and AIDS Global Programme, 5 March, 2008.

⁷ See draft literature review for more detail on drought, HIV and the “triple threat” in southern Africa.

⁸ These points are based on the hard copy of slides of general presentation shared with the researcher, as well as interviews with Disaster Management Unit and Water/Sanitation Unit.

3. Acceptance of the program and the water treatment by the community was good, due to a strong focus on explanation of the water treatment system and the goals of the project. A sensitization campaign was carried out in preparation of the project, to overcome skepticism and fear of the water purification tablets. First the government's buy-in was obtained, then community, district and household visits were carried out. Putting in place strong delivery/information mechanisms is very important in the situation of home based care. The water sanitation unit head explained that this kind of information campaign is just as vital in an emergency situation, in order to overcome superstitions about what the tablets are and the misinformation people may have about them.

In the discussion around this pilot, the water/sanitation unit head emphasized that persons without access to water and proper sanitation live in an acute situation. Thus, the tendency to describe only emergencies as acute situations is inadequate, as living without water is an emergency. Yet, the pilot project was designed to test home based care provision as the mechanism for providing water purification, under non-emergency conditions. As the impacts of the current violence in Kenya have disrupted the pilot, it will be important to see the impacts of that disruption.

3. Challenges

Some of the challenges of responding to HIV in a natural disaster naturally emerged from the interviews and the readings. The main issues revolved around: limited information collection for the HIV situation; the short time span of the response; increased role of national societies; a lack of cooperation between humanitarian actors and HIV programmers; and the general sentiment that HIV is not a priority in an emergency response.

3.1 Limited information collection on HIV

Information on HIV is not consistently collected during a disaster response. In a quick look at some of the tools that IFRC uses to prepare appeals, or assessments, there was little attention to HIV. In the internal guidelines for developing an appeal, there are two questions that include reference to HIV, one under shelter and one within the assessment of the general situation.⁹ No other guiding questions or links with HIV are included. The guidelines for emergency assessment also include HIV prevalence data in the checklist of health information. Access to reproductive health services and treatment protocols for sexually transmitted infections (STIs) are also questions listed in the checklist.¹⁰

IFRC has also developed a vulnerability and capacity assessment (VCA) tool, which aims to collect and analyze information on a community's vulnerability to hazards with the eventual aim of increasing resilience to disasters. The VCA includes public health questions but not detail on HIV. It reads as follows: 8. Health and nutritional conditions

- Most common illnesses among the general population (measles, HIV/AIDS, influenza, pneumonia, dengue, cholera, typhoid, diarrhea, intestinal parasites)¹¹

As these questions are guiding questions for national societies and individuals, it is difficult to ascertain whether or not they are used, and if so, if they are adequate to help in responding to HIV vulnerabilities. It is clear from the general nature of the questions that someone without sufficient background or preparedness in HIV may not make links between HIV and other sectors, such as shelter, education and nutrition.

⁹ Internal IFRC documents on intranet, shown to researcher.

¹⁰ IFRC, Guidelines for emergency assessment, October 2005, p.62.

¹¹ IFRC, VCA toolbox, 2006, p. 55.

3.2 Short time span of response

In a natural disaster, displacements are often short-term and the response is limited in duration. Members of the disaster response unit explained that the time frame for carrying out interventions determines the focus of the response. In a natural disaster, IFRC acts as a “referral hospital or drug dispensary.”¹² While data would be collected on people treated or referred by IFRC, no longer-term interventions would be undertaken. In practice, this means that IFRC does not carry out HIV counseling or testing (or TB testing) due to their inability to follow up. One respondent mentioned the recent floods in Kenya as an example. There, records on HIV were not taken, nor were VCT or ARV interventions implemented. When interviewees were asked about what kind of minimum standard protocol is used in an emergency, the response was that the Federation is committed to the Minimum Initial Services Package (MISP)¹³ and international guidelines on ARV policy.

3.3 Increased role of National Societies

The overall size of the International Federation’s response to disasters is shrinking. Today, national societies carry out the bulk of the response, for example of 1515 responses in 2007, the Federation carried out only 340.¹⁴ The rest were carried out by national societies. This is a challenge to the Federation’s ability to influence HIV response, as the role of the Federation is to support the response of national societies. In addition, the need for capacity building for the national societies’ HIV programs may limit their involvement in a disaster response (see section 2.1 and the discussion of HIV versus disasters).

3.4 Limited cooperation among HIV and humanitarian actors

Many respondents mentioned limited cooperation between HIV workers and humanitarian actors in humanitarian response situations. The activities still seem to take place on parallel tracks, rather than being planned and implemented together. The IFRC evaluation report notes this phenomenon as well, “There is very little programme connection, especially outside the health sector. HIV/AIDS is not mainstreamed in the organization.....HIV/AIDS programming in emergency settings is still underdeveloped, due to the different timeframes and the different character of the responses.”¹⁵

3.5 HIV is not a priority in emergency response

IFRC staff interviewed, noted a disconnect amongst the disaster response workers and the HIV workers. In many cases, no one with HIV expertise was present to advise or cooperate during a disaster response. One respondent explained the shock and dismay around which HIV services were dismissed during an inter-cluster discussion in Uganda.

This apparent disconnect may be due to the fact that HIV is not seen as a priority, or as a life saving intervention. This was stated clearly in several conversations. It is also reinforced in the Tsunami report by The Asian Network of People Living with HIV/AIDS (ANP+). The positive associations that undertook the ANP+ report made the point that that they do not expect persons living with HIV to be singled out in the immediate response. Rather, looking at vulnerable groups

¹² Piero Calvi, interview IFRC, March 2008.

¹³ The MISP was developed by UNFPA (?) specifically focusing on reproductive health in a crisis situation.

¹⁴ Presentation Climate change, disasters and health: The Red Cross Red Crescent response, hard copy passed to research by Piero Calvi.

¹⁵ IFRC Evaluation report, p. 35.

and their specific needs is expected to come after the immediate interventions. In the case of HIV, this is sometimes difficult, because the issue is often “hidden” and increased risk of transmission cannot only be addressed as an afterthought. To be effective in responding, HIV interactions must be in the minds of those carrying out the disaster response, hence the need for preparedness. This inability to find those living with HIV is only reinforced by the strong stigma and discrimination that was evident in the stories coming from the report. As the report recommends, persons living with HIV should be engaged to seek out others living with HIV. There was some criticism that UNAIDS’ very low assessment of PLHIV in Aceh emerged without the participation of PLHIV. Had PLHIV been involved, the estimates may have been higher, as they might have been better able to identify positive persons and gain access to informal positive networks.

4. Specific findings from the field

This section summarizes the key relevant conclusions from specific case studies, assessments or report on HIV vulnerabilities after a disaster. As the material was so limited, each study is presented separately here and the general conclusions drawn in section 5.

4.1 Study on Asian Tsunami by ANP+

While an impact/vulnerability assessment for PLHIV does not exist in the IFRC documentation reviewed, the closest piece of work is an ANP+ review carried out after Tsunami with IFRC financial support. The findings imply both positive and negative affects of natural disaster on persons living with HIV. The study was conducted through community interviews with positive people affected by the Tsunami, site visits to the countries involved, including interviews with PLHIV groups and local organizations, and a desk review. A questionnaire was designed in English and translated into local languages after being pilot tested. The study does not claim to be academic research, but a simple peer led assessment of the Tsunami’s impact on PLHIV.

The stated aim of the project was to: “To analyze the affect of the Asian Tsunami on people living with HIV/AIDS (PLHIV) in four countries in the region (Indonesia, Sri Lanka, Thailand and India) and provide lessons, recommendations and guidelines on how to manage this issue effectively in future disaster situations.”¹⁶

The final recommendations for organisations involved in emergency and disaster responses were:

1. HIV must be appropriately integrated into all emergency and disaster guidelines, and those guidelines appropriately implemented by all organisations involved in emergency and disaster responses;
2. The needs and issues relevant for positive people must be included and given appropriate emphasis within all guidelines and responses to emergencies and disasters;
3. GIPA (Greater [and more meaningful] Involvement of PLHIV) Principles, including community empowerment, partnerships and leadership, must be an underlying basic factor informing all facets of any response to HIV, including for emergencies and disasters.

The main findings:

- majority of persons interviewed became aware of their status **as a result of the Tsunami** and went onto treatment
- ARV access remained fairly constant
- Economic livelihoods declined

¹⁶ ANP+, The Asian Tsunami: An analysis of its effect on People Living with HIV and AIDS Project Report April 2007.

- PLHIV found by PLHIV (via positive networks)
- Strong stigma and discrimination in communities unprepared for the information

Greater awareness of status

The study suggests that the lives of some persons living with HIV in India were actually saved because they were tested, found positive, and able to access treatment and care services due to the increased availability of these services due to the Tsunami.

It is noted that many positive people interviewed as part of this Project, particularly in Tamil Nadu State in India, became aware of their positive HIV status only after the Tsunami due to medical care provided to them for various health problems often linked to the effect of the Tsunami¹⁷.

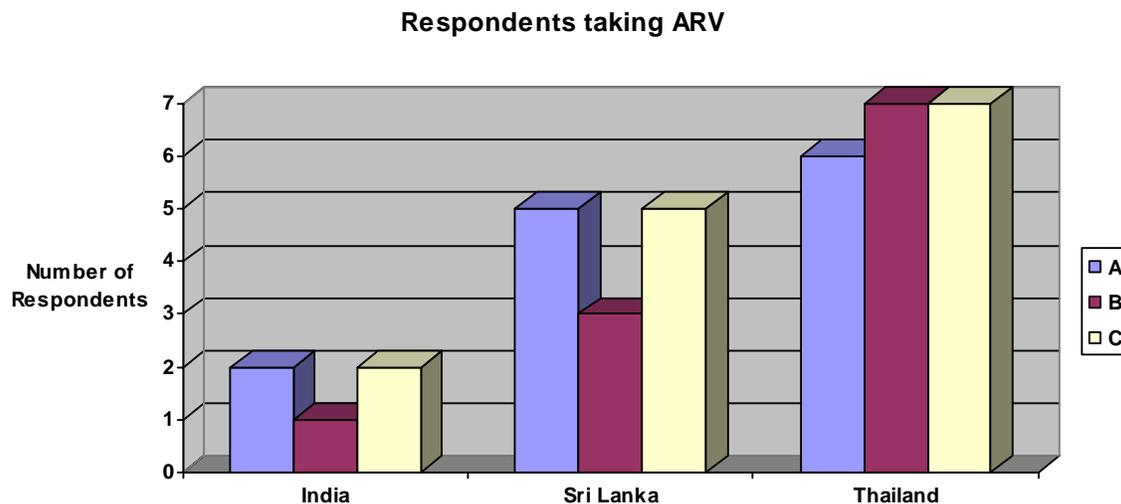
15 of 36 persons interviewed learned of their positive status after the Tsunami, when they presented with health problems such as diarrhoea, fever and non-healing wounds.¹⁸

Therefore, the study could lead to the interpretation that there is a potential positive effect in the case of natural disasters. The increased attention and availability of health services, including in this case, testing and treatment for HIV, made it possible for persons previously untested to get tested. As well, it made treatment and care possible, in cases where either 1) the services were previously not available, or 2) persons previously unwilling or unable to be tested were in a situation where testing was possible and encouraged.

ARV

The access and use of ARVs remained about the same as before the Tsunami, immediately after and at the time of the study (more than one year after the Tsunami).

The level at which ARVs (HIV antiretroviral medications) is being taken by our respondents has remained fairly constant at about a third. Before the Tsunami 36% (13) of respondents reported taking ARV, 31% (11) immediately after the Tsunami and 39% (14) now.



Note: A= pre-Tsunami; B= immediately after the Tsunami and C= now/time of study

¹⁷ ANP+, Tsunami report, Executive summary

¹⁸ Ibid, p. 14.

This does not necessarily show a continuation of treatment, as the persons receiving ARV may have changed. Some individuals did not discover their status until after the Tsunami, so presumably, they may have begun treatment later. It is unclear if persons who were on treatment pre-Tsunami are the same persons who were still on treatment post-Tsunami. The data also does not tell us who had their treatment disrupted and if so, for how long.

Opportunistic infections

The assessment noted an increase in the taking of HIV medications or prophylaxis for opportunistic infections, with an increase from 10 to 16 respondents taking these. The most common reported medicines were Bactrim and Fluconazole. Reported opportunistic infections include: oral candidiasis, diarrhea, skin rashes and Tuberculosis. As noted above, the increase in opportunistic infection and treatment seeking behavior appears to have led to increased HIV testing.

Access to food

Respondents reported an increase in difficulty in accessing food after the Tsunami, from 10 persons having trouble before, to 30 in the immediate aftermath to 25 now. Four respondents in India noted public kitchens as their means of accessing food immediately after the Tsunami. Nowhere in the report were food issues related to ARV adherence, perhaps because the sampling size was small, and because overall food insecurity was a greater issue.

Living conditions

There was an increase in the use of temporary shelters following the Tsunami, from 1 person before to 9 people immediate following the Tsunami to 10 now. While not linked with HIV in this report, overcrowded temporary living conditions have been associated with increases in sexual behavior and increased risk of HIV.¹⁹

High level of stigma

The most striking part of the report is the reminder of the stigma and discrimination that exists, notably among health workers as well, especially in communities unfamiliar with HIV.

Sri Lankan respondent IV told of how members of the community had thrown their two children down the well when they found out they were HIV+, like them. One of their children died due to injuries caused in the fall.²⁰

Villagers drove out an entire family when the husband was found out to be HIV+ so he automatically lost his job. After his death his wife was finally permitted to return to her house with her four children only because they believe up to this day that she is negative though in fact she too is HIV+. She does not dare apply for a job in the vicinity as she is fearful that one day she will be thrown out of it.²¹

Because HIV was taboo before the Tsunami, it is difficult to say if this level of stigma was higher due to the Tsunami, or simply due to the fact that several persons kept their HIV status hidden. When asked directly about stigma, PLHIV respondents did not express a level of personally feeling discriminated against; however this is contradicted by the above-mentioned stories.

Prevention

Most post-Tsunami efforts were focused on prevention. Some programs introduced information on HIV during the relief efforts. This may be because, in places such as Aceh, there were small known numbers of persons living with HIV.

¹⁹ See IOM and synthesis reports for more on shelter issues, specifically Swasti/Oxfam study on HIV vulnerabilities in India after the Tsunami.

²⁰ ANP+, Tsunami report, p. 18.

²¹ Ibid, p. 30.

Unemployment

Some of the other findings focus on unemployment and education. As to be expected, unemployment increased post-Tsunami. *“Pre-Tsunami 25% (9) reported being unemployed, this increased to 69% (25) immediately after the Tsunami and has now decreased to 47% (17), but even that lesser rate is still nearly double pre-Tsunami levels.”*

The report attributes some of this decrease to inability of workers to return to the Middle East, where they were previously employed, due to their positive status. The reports suggest that some workers may have contracted HIV in the Middle East, and are now unable to travel due to travel restrictions based on their HIV status. What is not explored, and may be of interest, is specifically *what* employment this group had pre and post Tsunami. For example, how many of them were fishermen and unable to return to work?

The report does touch on changes in cultural patterns related to ability to earn. One respondent discussed how, due to his HIV positive status, his wife had become the main breadwinner. It would be interesting to understand how these changes in family roles play out in the future.

4.2 Uganda 2007 Floods

While researching natural disaster response with IFRC and IOM, the researcher came across an extensive mapping of available HIV services in IDP camps in northern and eastern Uganda, specifically focused on the districts of Gulu, Amuru, Kitgum, Pader, Lira, Oyam and Apac. This DFID-funded project was carried out with IOM during September to December 2006.²² The Uganda Red Cross Society participated in the response to the floods in eastern Uganda in September 2007. As the flooding in Uganda in September 2007 affected some of these districts (Kitgum, Pader and Lira), the researcher tried to find recent data from the URCS to compare to the baseline data found in the mapping exercise. While no quantitative data was available, an IFRC Geneva-based staff involved in the flood response and the Uganda Red Cross Society shared their impressions of the impact on HIV of the floods in eastern Uganda in September 2007.²³

None of the Ugandan Red Cross (URCS) flood interventions specifically addressed PLHIV. The recovery program focused on shelter, food security and health systems strengthening. ART was provided, but the supply was already inconsistent before the flooding. The Red Cross obtains their ART supply from the local government, which is not constant; they noted that NGOs have a more reliable supply chain.

The areas affected by the flooding were already politically unstable. Of the 300,000 persons displaced, PLHIV were affected, but there is no exact data on how many. These observations on the impacts of the floods on PLHIV come from the experience of Ugandan Red Cross via its home based care program in Kapelebyong sub-county in Amuria district²⁴ during and after the flood interventions:

1. Food crops were destroyed. This greatly affected household income, as the sale of agriculture is a main source of income. In many cases, this led to dependency on WFP food rations. In an interview update, URCS explained that these rations have been replaced by nutritional supplements in some cases and in other cases by agencies distributing seeds. Unfortunately, not much rain is expected, so the utility of planting seeds is in doubt.
2. Normal URCS income generation activities were disrupted. The recovery of small loans is still an issue. Many were benefiting from small (100,000 Ugandan shillings) loans, given out in a

²² The details of the mapping are summarized in the IOM report.

²³ They also shared the OCHA January 2008 evaluation of the flood response, which was taken into consideration in writing this section.

²⁴ Note that this is not Amuru district, but the more eastern district of Amuria.

revolving fund. Many were using these loans to generate income via farming. Animal husbandry projects such as piggeries were successful, but others had planted seeds and cannot recover the funds due to the destruction of crops. While the URCS is currently working to find other solutions, the debts incurred and the disruption of the loans remain an ongoing problem.

3. Road network destroyed – affecting antiretroviral therapy (ARV) supply and access and provision of health services. URCS provides transport for ART with Uganda Cares.²⁵ Road destruction meant disrupted supply of ARVs from government to health centers, particularly in Katakwi and Amuria districts. Disruptions of up to one month caused brief discontinuation of ARV.
4. Amuria and Katakwi districts have some of the lowest health staffing levels in Uganda. This was further worsened as health workers were displaced, and sought refuge. This is supported in the January 2008 OCHA assessment, in the pre-existing problems in health systems:

Inadequate staffing at the health centres affected the response in the health sector. For example, current health staffing in Amuria is 21% and in Katakwi is 48%. There is also a weakness in drug management, which regularly results in up to 3 months drugs stock-out in the affected districts. Supplementary Village Health Teams (VHTs) existed but were not functional at the time of the floods, and as a result vital response time was lost to training VHTs to provide the services that they were set up to supply. These structural issues negatively impacted on the ability of the health systems to provide a timely emergency response to the affected communities.

5. Care givers were displaced and home based care disrupted, leaving PLHIV with no help.
6. Overcrowding in temporary shelters (schools) increased vulnerability to infections, especially to air born disease. Many people who were previously living on homesteads now seem to be moving between the temporary shelters and their homes.
7. Overcrowding led to an increase in sexual and gender based violence (SGBV). These reports were anecdotal, but the HIV programmers were left with the impression that they reflected an increase. Gender based activities were started by the URCS last year to sensitize people to the effects of SGBV. Cases of violence go unreported do to the strong stigma and discrimination associated with these cases.
8. Disease risks were prevalent. In the response to a malaria outbreak, PLHIV were given priority in net distribution. As well, water contamination increased PLHIV vulnerability. Water-logged latrines and improper waste disposal were also mentioned as factors increasing disease risk.

The immediate effects on livelihoods due to agricultural loss are clear. It seems that ARV supply has for the most part returned to the norm for these areas. What is less clear is the impact on PLHIV who had treatment disrupted, or who were left at home unattended.

5. Conclusions

IFRC is scaling up its own HIV policy, but its ability to respond to HIV in a natural disaster is dependent on the capacity of its national societies. The focus that the Federation is placing on building that capacity is important, as the vast majority of natural disaster response is led by national societies today.

²⁵ Uganda CARES is a partnership between the AIDS Healthcare Foundation and the Uganda Ministry of Health. The first Uganda CARES clinic opened in Masaka in February, 2001. Supporting partners include The AIDS Service Organization (TASO), Jesus Loves You, and AidChild. The project assists in ARV access outside of Kampala.

Data about PLHIV in natural disasters is not consistently collected. This may be due to the overriding view that HIV response is not a priority, life-saving intervention in an emergency. Where information is available, it is limited in its time frame, and does not necessarily look at the medium and longer-term impacts. The ANP+ report from the Tsunami is the only study found via IFRC that looks distinctly at the condition of PLHIV before, immediately after and a little more than one year after the disaster. This staggered time period is important to see the implications of HIV transmission, livelihood changes and disruption of health services, including ART.

One positive benefit of the increased focus on HIV post-Tsunami, as noted in the ANP+ report, is the rise in the number of people who learned their status. This seems to be due to an increase in attention to HIV, and chances for testing that did not exist previously. In cases where people presented with other illnesses caused by the Tsunami, their status was discovered due to the relief response that provided the opportunity to test. Moreover, it appears that some persons who tested positive were able to access treatment and care because of increased aid after the Tsunami.

The reports read and collected here show clearly that stigma and discrimination play a major role in inhibiting access to services. Stigma limits women's disclosure of sexual violence, and presumably the time frame in which they could access treatment such as post-exposure prophylaxis (PEP).²⁶ Stigma prohibits PLHIV from accessing health services, but also from accessing communal and household care for fear of disclosure; and stigma incites sometimes violent reactions against PLHIV, as shown in Sri Lanka.

It is unclear whether prevention efforts such as sensitization and information campaigns, a normal response in the wake of a natural disaster, are helping to make communities more accepting of PLHIV. The short time frame of these interventions and their "one-off" nature arguably makes them less effective. This raises questions about their ability to be integrated into the longer term development stage.

²⁶ However, information on where PEP is available and in what supply was not found in this study.

6. Persons contacted/interviewed:

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Awaiting response:
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IFRC Mozambique

Adelheid Marschang
Former IFRC, now in Sudan

7. Documents reviewed

IFRC, Global Alliance overview, 2006

IFRC, HIV/AIDS policy, 2002.

IFRC Point of View: Health: Water, Sanitation/Hygiene and PLWHA, 2005
HIV/AIDS CD, including Assessment report and program guidance

ANP+, The Asian Tsunami: An analysis of its effect on People Living with HIV and AIDS, Project Report, April 2007.

OCHA, Uganda Floods, Lessons Learnt, January 2008.

Uganda Red Cross Society, HIV lessons from the floods document

Uganda Red Cross Society, Assessment Report Karamoja region, 2007.

Southern Africa...Not business as usual. IFRC 2003.

2003 IFRC report on Southern Africa... not business as usual. Outlines HIV/AIDS links to food insecurity and poverty and suggests a model for addressing needs. The community care package suggested includes a holistic approach list, with TB DOTs and Malaria prevention. See page 13 of report.

A Long Way – The Lake Victoria Programme, IFRC, E3000/2007.

Details a SIDA-funded project of the Swedish Red Cross to address health, (specifically through reducing HIV/AIDS prevalence through behavior change, communications and support); disaster management; and capacity building. Focus on fishing as livelihoods in Lake Victoria and small income generating projects. The report mentions the high number of AIDS orphans, the presence of commercial sex work to raise money. The report mentions prevalence of 35% in some areas, attributed to cultural practices such as wife inheritance and the “high numbers of prostitutes who are involved in the fishing trade.” (p. 10). A high HIV area with heavy flooding, worsened by deforestation and poverty.

Mozambique: cyclone early warning system in practice, case study IFRC, 5/2007.

Mentions HIV prevalence but makes no direct links with the situation and those living with HIV. Does talk about the success of local disaster committees created in 2002 in the early warning of Cyclone Favio in February 2007.

Supporting global tuberculosis control. Links with HIV and RCRC as part of move to MDGs and work with WHO.

TB-HIV Strategic review, British Red Cross, 2008.

Discussion of Mozambican and Kenyan HIV and TB integration/national response. No discussion of natural disasters or conflict in the interaction. Points made that scale up needed, greater linkages must be made, and data collection on TB is missing. No links to sudden onset disasters or others.

VCA Training case studies: Annex F: Sri Lanka.

In the discussion of VCA post-Tsunami, one finding was of advocacy success using the VCA. The government agreed to put up streetlights on access roads to the village, making it safer for women at night. This is not linked in the text or case study to HIV, but has

implications for female safety, reduction of SGBV and lowered risk of HIV transmission. P. 27

Health: Water, Sanitation/Hygiene and PLWHA. Point of view of IFRC, guidance. 2005.

Case study 3/2007: Community home-based care for people living with HIV/AIDS in Zimbabwe. Focus on emergency, but need to address longer-term vulnerability. This document looks as IAP Integrated AIDS Project and HBC and recent developments from 2002-3 drought. HBC allows for care in home with family; food was needed and provided; food has acted as an economic transfer; social networks for psychological support set up.

Good practice: HIV and livelihoods in Africa: What can National Societies do? 12/2007.

Case study: Ethiopian droughts: reducing the risk to livelihoods through cash transfers. 11/2003 IFRC.