Review of International Organization for Migration (IOM) material on HIV and AIDS and sudden-onset emergencies

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

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANP+	The Asian Network of People Living with HIV/AIDS
ART	Anti-retroviral therapy
ARV	Anti-retroviral therapy, used inter-changeably with ART
BCC	Behavioral Change Communication
CAP	Consolidated Appeal Process
CBO	Community Based Organization
CCCM	Camp Coordination and Camp Management
CERF	Central Emergency Response Fund The Central Emergency Response Fund (CERF) is a stand-by fund established by the United Nations to enable more timely and reliable humanitarian assistance to those affected by natural disasters and armed conflicts.
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
DFID	UK Department for International Development
FARC	Revolutionary Armed Forces of Colombia
FBO	Faith based organization
Flash Appeal	A flash appeal is an emergency financial appeal, based on a rapid assessment of programming needs. It is issued 2-4 days after an emergency and for up to 3-6 months
GBV	Gender based violence
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GNP+	The Global Network of People Living with HIV/AIDS
HBC	Home based care
HCT	HIV counseling and testing
IFRC	International Federation of Red Cross and Red Crescent Societies
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
IDY	Internally displace youth
IEC	Information, Education and Communication
IOM	International Organizations for Migration
MSF	Medecins Sans Frontieres
MISP	Minimum Initial Services Package
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
ODI	Overseas Development Institute
OM	Operation Murambatsvina
OVC	Orphans and other vulnerable children
PEP	Post exposure prophylaxis
PMTCT	Prevention of mother to child transmission
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
TB	Tuberculosis
UCC	UNAIDS Country Coordinator
UNAIDS	The United Nations Joint Programme on HIV/AIDS
URCS	Uganda Red Cross Society
VCA	Vulnerability and capacity assessment
VCT	Voluntary counselling and testing
WFP	World Food Programme

Executive summary

With the implementation of the cluster approach[1] in responding to emergencies, IOM is mandated to lead on Camp Coordination and Camp Management for natural disaster-induced IDPs. IOM has experience with HIV in other sectors, such as shelter, food distribution and water/sanitation, as well as in evaluations of resettlement and returns. The cluster approach is still incorporating the response to HIV, and IOM has been actively involved in training others on the Inter-Agency Standing Committee (IASC) Guidelines for HIV in Emergency Settings[2] in Zimbabwe.

The majority of IOM's data deals with migrants, be they internal, international, documented or forcibly migrating. IOM has carried out some studies on HIV vulnerability, specifically in Colombia with internally displaced youth and in Zimbabwe around Operation Murambatsvina. Both of these studies provide useful data on vulnerability factors, but they are not linked to natural disasters. In the case of the Colombia study, the conditions reflect a chronic situation of displacement due to continuing conflict. The majority of data came out of Zimbabwe and was not the result of a natural disaster. However, Operation Murambatsvina was a sudden onset displacement and provides insights into HIV vulnerabilities that are supported by assessments carried during the emergency response, which is rare.

IOM has carried out an in-depth study of the affects of the Tsunami on migrants. This study touches on vulnerabilities to both migration and HIV, and inferences based on the situation seem to support other information about the impact of the Tsunami. The IOM study draws out two new aspects in the research around HIV vulnerabilities: 1) migration as a compounding factor in vulnerability and as a livelihoods strategy; and 2) remittances and their support in sustaining livelihoods after a natural disaster. IOM research posits that remittances increase after a natural disaster. If this is the case, remittances may help households to cope with the shock and protect them from having to adopt behaviors that increase exposure to HIV, thereby reducing their vulnerability.

The data describing the impact of natural disasters on HIV was missing in most interviews or not found in the documentation passed onto the researcher. However, IOM has been involved in the collection of baseline data for future impact assessments and research. In Uganda, IOM participated in DFID[3]-funded data collection on HIV in IDP camps in the north and eastern part of the country. In Somalia, IOM is carrying out "hot-spot mapping" in which they have collected data on risk behaviours among sex workers and their clients and PLHIV.

The only study found via IOM that directly relates natural disaster to increased HIV vulnerability was carried out in India by Oxfam and Swasti[4]. This study concluded that in 29 of 30 Indian coast communities surveyed already vulnerable to HIV, vulnerability had increased in at least two-thirds of the communities due to the Tsunami. The key factor noted in this increase was shelter design. The close physical proximity, as well as the lack of privacy for sexual relations between married couples (leading to the trend of seeking sex outside the couple) were both mentioned as having a high impact on vulnerability increase. Another finding was that the cash given out as part of the response was sufficient enough that several persons did not need to seek work, and were left with

[1] 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

[2] The Inter-Agency Standing Committee (IASC) was established in June 1992 in response to General Assembly Resolution 46/182 that called for strengthened coordination of humanitarian assistance. The guidelines can be found at: http://www.aidsandemergencies.org/resources.html.

[3] UK Department for International Development

[4] Swast is an Indian non-profit A health resource centre that seeks to improve health outcomes, working with communities and development partners through action research, consulting services and knowledge management, see www.swasti.org

extra money and free time, which resulted in increased drinking and engagement in commercial sex. Finally, local elders governing social norms were found to limit sexual behaviour and thereby reduce vulnerability in places where they remained intact with their community. Hence, the implications for shelter design to develop in such a way as to keep social structures as they were before the disaster, in hopes of maintaining some semblance of 'normal' social order.

Perhaps more striking than in other data, the studies collected via IOM show the additional burden of being a "hidden" migrant. The cases of Zimbabwean migrants in South Africa and the complete loss of identity of many after the Tsunami drive home the additional vulnerability of being 'paperless.' The studies recount the disruption of access to land, shelter, and essential services that follows, not to mention the added vulnerability to trafficking, and sexual exploitation that has clearly followed in the case of Zimbabweans.

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 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, Islene Araujo, via whom initial inquiries and requests for information were made. The majority of IOM staff involved were outside Geneva, so email and telephone inquiries were the main sources of information. Background data and relevant reports, evaluations, and findings were passed to the researcher or obtained from the IOM website. A complete list of reports shared and reviewed 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 actions that IOM took in a given 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 IOM. 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 IOM is not collecting this information. 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.

In the case of the information from the Bangladeshi NGO (section 4.3), language barriers limited the interpretation of information as well as the fact that no accompanying report to the presentation exist.[5] This presentation reflects preliminary findings, and the interpretation here has been cross-checked with IOM personnel in Bangladesh.

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 sections. Following this first section, the second section summarizes information learned about IOM's response to HIV, based on the information obtained during this research. This is a short narrative reflecting IOM interviews in regards to HIV response; it aims to give an overview of how the IOM treats HIV in an emergency. The third section discusses the challenges IOM has faced in 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 it summarizes the specific reports or assessments by country. There is such disparate information that drawing general conclusions is a stretch; hence, the research information is summarized by country information found, and general themes are noted in the concluding remarks.[6]

2. IOM's response to HIV

This section is a general discussion of IOM's experience with HIV. It is based on interviews, with the main informant being the point of contact at IOM. It touches on anecdotal responses, which are unfortunately not detailed with quantitative information in this research.

While IOM is mandated to work in natural disasters, its involvement in HIV varies depending on the context, the capacity of staff available and the evolution of the cluster approach[7]. IOM comes in at the request of the government, and works within the UN country team. While there are standard IOM operating procedures in a natural disaster, they do not include HIV.

Before the implementation of the cluster approach, IOM was involved in various sectors, including shelter, food distribution, water/ sanitation and HIV as well as evaluations on resettlement and

[5] AVAS, Effects of SIDOR/Sidr on sex workers in Bangladesh, shared via IOM.
[6] Please see the synthesis report for general themes based on both IFRC and IOM research findings.
[7] 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

return. IOM would work to include HIV in its activities, for example, before trucks unload food, drama groups would perform with HIV awareness messages and condoms would be distributed. IOM also implemented voluntary counselling and testing (VCT) in Internally Displaced Person (IDP) camps, and supported home based care (HBC) programs and targeted food distributions.

Within the cluster approach, IOM is responsible for Camp Coordination and Camp Management (CCCM) in cases of natural disaster-induced IDPs. While IOM still provides help in other areas as needed in a given response, e.g. shelter and water/sanitation, or food distribution (if WFP is not present), its mandate is now CCCM.

While there is some bilateral funding for IOM, the majority of funding comes through joint appeals, such as Flash Appeals[8], the Central Emergency Response Fund (CERF)[9] and Consolidated Appeals Process (CAP)[10]. Whether or not HIV will be mainstreamed depends on the capacity and integration of all the clusters, not just CCCM. These appeals are open to all IASC members and include multi-sectoral programming. It is not always clear, however, who should lead on programming for HIV. Joint funding can put organizations in competition for HIV funding.[11] As well, funds allotted to HIV are oftentimes difficult to itemize in a given appeal.

IOM has incorporated HIV into its responses in countries such as Angola, Colombia, and Zimbabwe. Colombia and Zimbabwe will be discussed below. Thus, for instance, IOM managed the return of thousands of Angolans without refugee status from Zambia to Angola. IOM's strategy during the repatriation of Angolans from Zambia and Democratic Republic of Congo was to empower the returnees so they are not seen as carriers of HIV infection. This was done via the creation of peer educators, trained in prevention. This ongoing approach is cited as a success, helping to reduce stigma and discrimination against migrants and returnees, and strengthening coping mechanisms.

2.1 Focus on gender and women's vulnerability in a response

During an emergency response in high prevalence countries, e.g. Zimbabwe, a key focus for IOM is to empower women, with the goal of achieving equity in accessing assistance. In many countries, including in Asia, the Middle East (Iraq), and Africa, cultural barriers reportedly keep women out of trainings, income generating projects, as well as off food distribution lists. In places where women are 'hidden' and men control access to information, as well as participation in activities outside the home, it becomes a challenge to include women. One example is the cultural tradition in many parts of Africa of dowry payments by the man's family for the bride. A girl's family can therefore generate income by pushing a child into early marriage or marriage during difficult times. The fact that the child can then be returned to the family encourages a form of prostitution of girls. A man can temporarily "buy" a wife and then send her home. This can make makes young women more vulnerable to HIV exposure, as they come under the sexual control of their husband, who may only keep them temporarily. As well, a family may be in greater financial need of a dowry during times of crisis thus "selling" off more girls during these periods.

[8] A flash appeal is an emergency financial appeal, based on a rapid assessment of programming needs. It is issued 2-4 days after an emergency and for up to 3-6 months

[9] The Central Emergency Response Fund (CERF) is a stand-by fund established by the United Nations to enable more timely and reliable humanitarian assistance to those affected by natural disasters and armed conflicts.

[10] The consolidated appeal is an inclusive funding mechanism for a programming cycle for a given country. It is the main tool of the humanitarian community for coordination, strategic planning and programming. It is prepared in consultation with the state concerned and issued 3-6 months of an emergency and annually if needed.

[11] This is structurally true, but one case of competition of funding was mentioned in an interview.

3. Challenges

This section explores briefly some of the challenges faced by IOM in including HIV in their disaster response.

3.1 Making the link in low-prevalence countries

In high prevalence countries, clearly persons living with HIV (PLHIV) are more numerous and more visible and similarly their needs are more urgent. In low prevalence countries, PLHIV are normally grouped in with other vulnerable groups, and not singled out for special treatment. For example, in Peru, safe blood supply was recognized as important for HIV, but HIV was not linked at all to issues of overcrowding, sexual and gender based violence (SGBV), and sex workers.

3.2 Short time frame of the response

The time frame of a natural disaster and the capacity of the responders also determine which interventions are possible. As a disaster strikes and ends suddenly, the time frame of the emergency intervention is relatively short. The humanitarian community responds with short, limited actions to undertake life-saving interventions. Thus, programs are only planned for the immediate intervention, not for more comprehensive approaches or health interventions that require a longer presence. According to one respondent, STIs are not addressed immediately, unless they are very serious. Only very obvious opportunistic infections [such as tuberculosis (TB)) are treated in the immediate.

3.3 Lack of capacity

Addressing Iraqi refugees in Syria and Jordan and Lebanon is one of IOM's largest operations. Yet, HIV is not included in any response due to lack of capacity. Clearly, these are also countries in which HIV prevalence rates are low, so even in 'normal' times they may not be a priority concern. IOM also played a large role in Peru after the earthquake, yet HIV was not included in the response due to the lack of IOM health staff in Peru and again, also possibly because of low prevalence rates and not recognising that HIV preparedness and action is needed.

3.4 Lack of operational guidance on HIV in humanitarian settings

HIV guidance for humanitarian settings is in the preliminary stages, with direction for integrating HIV into the cluster approach still under development. The IASC Guidelines for HIV in Emergency Settings are currently being updated. There is also no roll out strategy for training IOM staff. In the case of the earthquake response in Peru, a lack of funding to roll out training on the IASC Guidelines was cited as one of the reasons that HIV was not included in the response.

3.5 Data collection is not specific to mobility and HIV

In the case of mobility and migration in relation to the increased risk to HIV, behavioural data does not tell all. Is the migration flow due to conflict or natural disaster? Is the migrant residing permanently in a host country or only for a limited period? There has been no profiling of migration routes in relation to HIV vulnerability. A suggestion was put forward to map a route, say of Asian migrant workers in Eastern Europe, and their vulnerabilities, such as sex and drug use along the migratory route. This kind of data would help to determine underlying vulnerability and perhaps enable the disaggregation of 'underlying' versus 'sudden onset' vulnerability.

4. Specific findings from the field

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

4.1 Columbia[12]

In Colombia, IOM is involved in a program to address prevention issues of internally displaced youth (IDYs). In a report carried out last year by UNFPA, issues of HIV prevention among displaced youth in Colombia were analyzed. There are several findings relevant for HIV.

Higher sexual activity and lower levels of HIV knowledge
The analysis of displaced youth as a vulnerable group shows potential HIV vulnerability, with higher pregnancy rates among displaced women and an assumed rise in gender and sexual based violence.[13] Knowledge of HIV among this vulnerable group is low, as a "Profamilia[14] survey of 2000 found that adolescents displaced by armed conflict had the lowest level of knowledge of HIV, Acquired immune deficiency syndrome (AIDS), and sexually transmitted infections (STIs). The survey found that STIs among displaced populations were as common as respiratory illnesses and diarrhoea; yet only 28% of women were able to identify any symptoms of an STI."[15]

High level of stigma
Stigma and discrimination remain critical issues, as noted in the same study: "There are severe stigmatization and human rights abuses by armed groups against people perceived or known to be HIV-positive. NGOs permanently report that FARC (Revolutionary Armed Forces of Colombia) and paramilitary groups undertake "social cleansing" operations, killing people testing positive, known homosexuals, or commercial sex workers."

The report makes the case for prevention services to address the higher vulnerability of this group, but does not link specifically to a natural disaster. Rather, the backdrop is the ongoing conflict in Colombia. One can infer, however, that IDYs would only be more vulnerable in the case of sudden onset disasters, which would further disrupt already precarious living situations.

4.2 Zimbabwe

Although the data on Zimbabwe is linked to political strife more than natural disasters, Operation Murambatsvina was a sudden onset displacement. More importantly for this work, it has been assessed in terms of impact on those living with HIV by IOM. Because of high HIV prevalence rates in Zimbabwe, the vulnerability of the chronically ill has been documented.

IOM led the emergency response in Zimbabwe, responding to the needs of IDPs. There, IOM began mainstreaming HIV into emergencies. It was one of the first regions where the IASC Guidelines on HIV in Emergency Settings were introduced, and evaluations regarding the emergency and HIV have been carried out. One interviewee was involved in leading the response, and recounted her impressions. Persons living with HIV were already affected by hunger, unemployment, and lack of access to health care; they were singled out because of increased

[12] Evidence in this section is based on a case study carried out by UNFPA, *Light at the End of the Tunnel: HIV prevention for Colombia's Internally Displaced Youth*, with Margaret Snager centre International, 2007, passed via IOM.
[13] The report cites extraordinary violence against women due to armed conflict and abuse. While recognizing that many cases go unreported, the research references surveys carried out with displaced women, p. 10.
[14] Profamilia is an association promoting sexual and reproductive health services, see http://www.profamiliapr.org.
[15] UNFPA, *Light at the End of the Tunnel*, p. 11.

vulnerability. In some cases, the bed bound had their homes destroyed, therefore the response was an immediate life saving intervention. In their response, IOM was actively trying to identify PLHIV. During registration of the displaced, they were looking for the chronically ill (house bound, bed bounds, someone left behind) and orphans, or people living on the streets or without shelter starting to get sick (e.g. diarrhoea or vomiting). IOM made an agreement with clinics and discussed with others agencies what services could be offered, such as medicines and transport. The organizations present quickly determined which services were available amongst their own organizations and worked together in an informal network to meet needs to providers.

The main findings from the IOM research in Zimbabwe are summarized here[16]:

Home based care

During Operation Murambatsvina (OM), home based care (HBC) was disrupted. An assessment of home based care was carried out using two structured questionnaires, designed by UNCEF, UNAIDS and IOM. One was for HBC providers and the second was for IOM partners who assisted chronically ill and OVCs during OM. The exercise took place during the crisis (July 2005) and the results are based on twenty-nine sites surveyed, and 38 returned questionnaires. The results showed a **drastic decrease (77%) in the number of chronically ill assisted**, most likely due to displacement. Of the displaced HBC clients, the majority had moved in with extended family. Others moved back to the rural homestead, or into churches, warehouses or other temporary shelters. Smaller numbers were reportedly in transit camps or sleeping out in the open.

Of disrupted HBC activities, **home visits were the most affected**, with 82% of providers noting an inability to carry out such visits. The two main reasons cited for HBC disruptions were client displacement (86% cited this), and then volunteer displacement (82%).

ARV

During Operation Murambatsvina, antiretroviral treatment was not greatly disrupted. “Only 12.46% of those who were once on treatment were no longer receiving treatment.” And “out of 658 registered as having had treatment, 74 were no longer on treatment.”[17] The most common reason for treatment termination cited was transport (46% no longer had transport). The second most common reason was displacement (13.5%). Here treatment includes anti-retroviral treatment, TB treatment or opportunistic infection treatment and no differentiation was made amongst the different types; unfortunately, information disaggregated by type of treatment was not available in the report.

More recently, however, in a 2007 report on the state of Zimbabwean displaced in South Africa, it was implied that access to ARVs has been disrupted: “The Department of Health has recently instituted a directive that Antiretroviral Treatment for HIV and AIDS should be made available to refugees and asylum seekers irrespective of whether they hold documents; however, the Department has made no effort to facilitate the recruitment of qualified Zimbabwean medical personnel who are already in the country, in spite of a dire shortage of skills in this area”.[18]

“As noted above, there are currently no dedicated humanitarian services for Zimbabweans, access to mainstream housing, health care and emergency welfare services (such as the Social Relief of Distress grant) is limited, and non-governmental humanitarian responses are insufficient. Implications of a lack of humanitarian assistance include: Public health dangers associated with

[16] These findings are a summary of key reports passed to the researcher on Zimbabwe, including: IOM, Assessment of Operation Murambatsvina: Impact on HBC support, chronically ill, OVCs, gender violence and family structures, November 2005.; IOM, Final report to DFID: Urban displacements from Zimbabwe: Responses to HIV Vulnerability and Gender-Based Violence, 2006; Briefing note: Addressing HIV Vulnerability and Service Needs of Zimbabwean Migrant Populations in Southern Africa, 27 February 2008; Osman, M., Mainstreaming HIV/AIDS with Humanitarian Assistance for Internally Displaced Populations: Lessons from Zimbabwe 2005-2006, June 2006.

[17] IOM, Assessment of OM, p. 11.

[18] Report on state of Zimbabwe migrants in South Africa, p 12.

people with communicable diseases not being able to access medication, and the development of resistant strains of diseases such as TB and HIV due to interrupted treatment".[19]

Increase in unaccompanied children

After Operation Murambatsvina, the overall number of orphans and vulnerable children (OVCs) being assisted slightly decreased, presumably due to the difficulty of reaching them after the mass displacements. But generally, even in 'normal' circumstances, displacement of orphans and vulnerable children is widespread. There are many unaccompanied children in Limpopo, moving to earn money. According to a Save the Children UK report on unaccompanied minors who have travelled to South Africa, one of the reasons that children migrate alone is because they are orphaned due to AIDS, especially children from Zimbabwe and Mozambique.[20]

Increased vulnerability of women and girls

During Operation Murambatsvina, reports of sexual abuse emerged from the IOM survey.[21]Of 36 reported abuse cases, 35 were by women, and 31 were sexual. The reasons given included: girls/women sleeping in the open due to lack of accommodation; engagement in 'survival' sex for food, money or housing; separation of couples; male and female teenagers sleeping in the same room.

A more recent, confidential, briefing paper[22] discussing the HIV vulnerability of the Zimbabwean migrant population in Southern Africa, points to increased female vulnerability. "There are some indications that transactional sex is used as a livelihood strategy, either in direct commercial sex or through 'boyfriend/sugar daddy' relationships."[23]

The issue of female vulnerability is supported by other information in the reports, thus for instance is suggests that: "Local authorities, especially the Department of Social Development (DSD), need increased capacity to better respond to the increased influx of women and children. In particular, there are no shelters or "Places of Safety" in Musina." (IOM confidential report). Similarly, reports from Limpopo region suggest that women find shelter through South African partners, exposing them to sexual risks.

There are also increasing reports of new births in South Africa from both South African and Zimbabwean (documented/undocumented) fathers. The babies are reportedly the result of rape or a sugar daddy relationship. The report also notes that the children, lacking access to schooling and care, place an additional burden on their mothers. The reported lack of safe places in the shelters corroborates the notion that these births are not voluntary.

Zimbabwean migrants have been singled out as particularly vulnerable to gender based violence. This includes trafficking, rape, transactional sex, and commercial sex. A confidential assessment report[24] calls for immediately strengthening of GBV programming. The report also recommends giving Zimbabweans the same access to health care, education, and other services as the rest of the host (?) community in order to decrease these vulnerabilities. Ante-natal care, access to ARV and HIV-related services are pointed out as critical in such a high prevalence area.

[19] Ibid, p. 14.
[20] Save the Children, *Children crossing borders: report on unaccompanied minors who have travelled to South Africa*, July 2007.
[21] IOM, Assessment of Operation Murambatsvina: Impact on HBC support, chronically ill, OVCs, gender violence and family structures, November 2005
[22] Addressing HIV Vulnerability and Service Needs of Zimbabwean Migrant Population in Southern Africa, 27 February 2008. Input for this report comes from IOM, IFRC and UNHCR and was passed to the researcher via IFRC's Southern Africa regional office
[23] IOM, UNICEF, UNHCR confidential assessment "United Nations-International Organization for Migration (IOM) Joint-Assessment Report on the Situation of Migrants from Zimbabwe in South Africa," September 2007.
[24] Ibid.

A 2006 project report of an IOM GBV program[25] provides more details on female vulnerability: the project undertook activities to improve access and availability of condoms, disseminate behaviour change communication (BCC) material, and facilitate access of the displaced to voluntary testing and counselling (VCT), GBV prevention and care, Post Exposure Prophylaxis (PEP) and emergency contraception. The project was set up to address the reports of rape, women forced into unsafe sex, disruption of HBC and the need for condom distribution. To evaluate the project, IOM compared post intervention and baseline groups in seven randomly selected areas. The report details programmatic lessons learned and the data suggests that the project was successful in decreasing vulnerability in an emergency.
The following are some key findings drawn from the report:

- Condom availability and quality, as perceived by the groups interviewed, remained almost the same (80% versus 79%).
- Condom use amongst the intervention group in last sexual intercourse increased significantly (46% versus 13% of the baseline group).
- The project helped to decrease stigma and discrimination (77.6%), and the baseline group (68.9%).
- No differences were found on the comprehensive knowledge of HIV between the intervention and baseline groups. This is credited to the fact that the population concerned had a very high level of HIV awareness before the displacements. Therefore, resumption of services enabled these positive results.
- The program increased the number of persons seeking treatment for sexually transmitted infections from 35 to 57%.
- While there was no difference in the perceived availability of VCT, the number of persons tested increased. The large increase (57% versus 35%) may be due to the increase in VCT mobile clinics during the project.

Migrant vulnerabilities
A briefing paper by IOM on the specific vulnerabilities of Zimbabwean migrants gives the following main findings[26]:

- "Migrants may engage in casual sex or even connive in the sexual exploitation of others"
- These migrants, due to conditions of poverty, language barriers or fear, tend to have inadequate HIV prevention information and services (including treatment and legal advice)
- Stigma and discrimination are barriers to accessing services and are often reinforced by xenophobia.
- Recent studies[27] on these migrants are lacking critical information on HIV vulnerabilities and service needs.
- Anecdotal evidence that illegal or undocumented immigrants do not access health care out of fear of deportation/harassment.
- IOM reception centre in Beitbridge has some information indicating an increase in sexual vulnerability and violence

Increased HIV services
The emergency is sometimes viewed as the entry point for supplying or resuming services (in this case, health services) that were not previously accessible or that collect data and offer services may not have existed prior to an emergency.

Increased use of HIV services available
A related point is around the use of HIV and sexual and reproductive health services. Anecdotal and assessment reports support the fact that wider availability of condoms and services result in

[25] IOM, Urban Displacements in Zimbabwe: Responses to HIV Vulnerability and Gender-based Violence' report to DFID, June 2006.
[26] Addressing HIV Vulnerability and Service Needs of Zimbabwean Migrant Populations in Southern Africa, 27 February 2008.
[27] The briefing cites studies in Limpopo and Gauteng provinces of South Africa but does not give references.

wider use. The IOM project assessment survey reports show increased use with wider availability of condoms, higher rates of VCT with the availability of mobile clinics, and increases in health seeking behaviour with wider availability of STI treatment. When VCT was offered in Zimbabwe during the emergency response, the experience of one of the respondents is that people do want it and will take advantage of the opportunity to test.

4.3 Bangladesh

While IOM did not have direct studies on HIV in natural disasters, they did pass along an assessment done by a NGO called Avas. Avas (http://avas-bsl.org/) looked at impacts of cyclone Sidor[28]on sex workers in four areas: Barisal, Patuakhali, Kuakata, and Pirojpur. This is a preliminary informal study, translated to English. While it sheds some light on information concerning sex workers in different venues, there is no accompanying study to expound on the interviews or methodology. The presentation here has been verified with IOM in Bangladesh.

Effects on sex workers

The effects on the sex workers included:

- Reduced income
- Increase migration in search of income
- Change in livelihoods/destruction of livelihoods
- Decreased access to health services due to migration
- Increase frustration in family life and individual (psychological trauma, feelings of distress)

Table 1: Number of sex workers per venue

Based	Patuakhali	Kuakata	Pirojpur	Barisal	Total
Hotel	234	293	64	700	1291
Residence	143	44	70	-	257
Brothel	74	-	-	-	74
Total:	**451**	**337**	**134**	**700**	**1622**

Damage to place of work for sex workers

Of the 1291 sex workers reported working in hotels, 60% reported structural damage (including damage to furnishings), 95% reported damage to livestock, and 30% reported damage to trees due to the cyclone. Of the 257 working from residences,[29]67% experienced structural damage, 98% experienced damage to livestock and 30% experienced damage to trees.

While these are preliminary findings compiled by the NGO, the author notes that stigma and discrimination prevented the sex workers from revealing their profession during relief efforts, with the exception of Pirojpur.

[28] Cyclone Sidor (or Sidr) hit the coast of Bangladesh November 15, 2007, killing more than 3, 400 persons, and injuring nearly the same.

[29] According to Dr. Ali Amzad of IOM in Bangladesh, residences here are houses belonging either to sex worker or (mainly) some middle-men/women where commercial sex takes place. Usually 3-6 sex workers work together or are managed by the middle-men/women for commercial sex. This 'residence based sex work' is increasing rapidly due to the abolition of brothels and many clients' unease at visiting brothels. The managers of these 'residences' often shift/change the location of the house to maintain anonymity. This is also a reason for the rapid development of 'hotel-based' commercial sex work. These hotels are more known by the general public (apart from the clients) than the 'residences'. There are quite a few hotels for mainly commercial sex work.

Children of sex workers

A discussion as to the impacts of the cyclone on the children of the sex workers, showed that of the 230 children total of the sex workers in all four areas, almost all (207) were malnourished because of Sidor, more than half were ill and 37 were injured, with 33 described as "beyond treatment," and 96 undergoing treatment. The author records what kind of aid was supplied by whom, showing that more assistance came from non-governmental sources.

The implications of the findings are left to the audience to surmise, but it is clear that the majority of sex workers in the survey had their places of work damaged or destroyed, implying income loss and livelihoods disruption. As well, the families of the sex workers have been clearly disrupted, as evidenced by the effects on their children.

4.4 Somalia

Discussions with IOM field persons in Nairobi led to an interview with the UNAIDS Country Coordinator of Somalia and information about current data collection going on in the country. The UCC[30] in Somalia describes the response as an ongoing emergency. With 1.82 million made vulnerable by conflict and displacement, almost the entire country is internally displaced. The value added in a given response, or the impact from one crisis on top of the others is not disaggregated in the information. High population mobility and political instability breed HIV vulnerability, and all of Somalia's three zones (Central South, Puntland and Somaliland) experience these conditions.

In Somalia, AIDS is mainstreamed into the emergency humanitarian response, via the IASC clusters, and the humanitarian appeal mechanisms. AIDS is a joint program within the UN Transition Plan 2008 – 2010 as well as the 5 year reconstruction and development plan.

Mapping of sex workers and their clients

In an attempt to begin to collect data and measure the impacts on PLHIV, IOM is carrying out its first "hot-spot mapping" in Somalia, with support from UNAIDS and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) partners. They have recently finished reporting on risk behaviours among sex workers and their clients and people living with HIV. According to Leo Kenny, UCC of Somalia, the IOM work is important because it helps redirect resources form GFATM and UN towards addressing most at risk groups – mobile populations, sex workers, truck drivers etc. Although the second round of ANC surveillance is being completed, it is not giving us information on the drivers of the Somali epidemic. The IOM work gives us a basis to reach these most at risk populations."

The Hot-spot mapping has established an evidence-base for the development of the first Somali National HIV Sero-Behavioural Survey among Most at Risk Populations in 2008. It has also challenged the idea that sexual behaviour research was not possible in Somalia. The sub-populations among the sex workers and their clients in the mapping include asylum seekers, refugees, internally displaced persons, uniformed services, militia, seafarers and truck drivers. With a response rate was 93%, the main findings were:

- Entry into 'survival sex' work was most common, particularly among women who headed their household
- Sex workers and their clients reported highly inconsistent or no use of condoms
- Cost per sex act was as low as US$0.50 and as high as US$ 250
- High levels of mobility among transactional sex workers both before and after starting transactional sex
- Sex workers' clients, e.g. uniformed services and truck drivers,[31] reported inconsistent condom use with multiple, concurrent sexual partners in multiple locations among mobile populations

[30] Leo Kenny, UNAIDS
[31] CRIS and Somalia newsletter, February 2008.

UN agencies are addressing HIV vulnerability amongst IDPs in South Central Somalia. Focused on delivering a minimum package response to GBV, UNFPA has been training health care providers in responding to GBV survivors. UNDP has addressed religious leaders in training on HIV, Islam and GBV.

4.5 Uganda

The Uganda mapping project (funded by DFID and carried out by IOM from September to December 2006) was undertaken to examine heightened vulnerability to HIV due to twenty years of conflict in northern Uganda. The study looked at IDP camps in the districts of Gulu, Amuru, Kitgum, Pader, Lira, Oyam and Apac, with interviews in a total of 198 sites. Two data collection forms, one for service providers and one for IDP community leadership forums, were developed and given to respondents.

While services varied, there was general agreement that the number of OVC and PLHIV was overwhelming and increased inputs (financing and staff) were needed. Coordination and information flow among the communities needed to be improved to ensure accurate information and effective referrals.

Pader district was the least serviced area. Pader was affected by recent flooding in the eastern part of Uganda, so it would be interesting to look at increased vulnerabilities there, or to see if the report's findings resulted in increased attention to IDPs in this area during the flooding as regards HIV programming. That information was not found during this research, but may be pursued as the baseline data is quite recent. The information gathered was on the accessibility of services in the IDP camps.

HIV related services were found to be more available in health clinics or hospitals, but remain inadequate to meet the high demand in IDP locations. The most widely available services were Information, Education and Communication (IEC) (most common) and condom distribution. Condom distribution was still considered lacking, with insufficient amounts of condoms available to be distributed. IEC failed to make critical links between sexual and gender based violence and HIV infection, nor to promote preventative testing and counseling.

Counseling and testing

Health providers said that 85% of them offer HIV counseling and 44% offer HIV testing to IDPs. HIV Counseling and Testing (HCT) service providers generally operate from mobile clinics rather than in the established health clinics of IDP sites (with the exception of MSF). Lack of access was reported by IDP leadership, credited to a lack of test kits and long travel distances. The fact that several health facilities reported higher testing than counseling numbers was of concern. This implies that counseling is not routine and tests are being administered without preparing patients for their results.

Prevention of Mother to Child Transmission (PMTCT)

PMTCT services are offered mainly by health facilities, rarely by NGOs, Community based organizations (CBOs) and Faith-based organizations (FBOs). The majority of hospitals and some health clinics reported testing for PMTCT. IDP leadership reported that only 90 of 198 sites are able to test for PMTCT and 138 of 198 sites have counseling for PMTCT. Drugs for PMTCT were reported available and free of charge by IDP leadership in 38% of the locations. Nutritional support was reported available in 46 of 198 sites. Only 19% of respondents said that PMTCT services are accessible to all in need.

STI

While STI treatment was said to be offered in the majority of health facilities, the level of care varied. A lack of drugs, equipment and staff has resulted in referrals or under-dosages. The

transport expense of reaching another health facility was noted as a prohibitive factor in accessing treatment. IDP leadership reported that 71% of their communities had access to STI treatment, but only 23% of respondents reported STI treatment as accessible to all who need it.

Pediatric care
Pediatric HIV treatment was found to be most lacking, with little or no services provided. The report makes clear that even a positive response to service provision does not mean that all in need are accessing the services, as demand far outweighs supply, as especially noted in the case of services for orphans and vulnerable children.

ART
Provision of ART is minimal and does not meet the needs of the IDP communities. The IDP leadership responded at a rate of 79% saying that community members access ART, but only 21% agreed that access was available to all who need it. In Pader district, only 24% said that ART is accessed. The leadership stated reasons for lack of access as: the high number of those in need; the poor capacity of health staff (not enough and not qualified); and the expense, which is transport-related as the drugs are free.

Opportunistic Infections (OIs)
Treatment for OIs is available in health facilities and in some mobile clinics run by NGOs, FBOs or CBOs. In facilities that do not offer HIV testing, health workers cannot differentiate between OIs and an infection. IDP leadership reported 76% accessibility to treatment for OIs, but only 35% said that treatment is available for all those in need. Again, the high level of demand, a lack of drugs, equipment and staff were all cited as reasons. As well, under-dosing of drugs was a common complaint, blamed on supply constraints.

Home based care (HBC)
Home based care is not widely available, but needed, as stated by service providers and IDP leaders. A little more than half of the service providers and health facilities provide HBC services. The services offered within HBC differ by community and not all areas offer comprehensive packages.

Orphans and vulnerable children (OVC)
Programs to help orphans and other vulnerable children are badly needed. Service providers describe the number of current beneficiaries as overwhelming, although 73% of service providers interviewed do provide some services, they are unable to meet the full need. Fourteen out of 26 IDP locations were receiving no OVC services. Common types of support include educational, medical and psychosocial aid, with some nutritional assistance.

Referrals
Referrals made by a clinic or service provider were not always followed up on by the patient or the referred provider. This was accredited to: lack of coordination; lack of transport or the high cost of transport to carry out referrals to other areas; the long waiting time; the high number of beneficiaries, and the lack of capacity of the referred facility.

4.6 Tsunami

During the Tsunami response, IOM HIV programs addressed primarily sex workers, cross border traders, and other displaced populations. IOM used the response to the Tsunami to step up HIV prevention information. The affects of the Tsunami on HIV vulnerability have been studied by ANP+ as well as by Swasti and Oxfam. IOM has carried out a study on the affects of the Tsunami on migrants.[32] While this study does not focus on HIV vulnerability, it does point out trends and

[32] The report highlighted in this section is: Asmita Naik, Elca Stigter and Frank Laczko, Migration, Development and Natural Disasters: Insights from the Indian Ocean Tsunami. IOM Migration research series, no 30, 2007.

evidence that support work on HIV vulnerability mentioned in the two other assessments, one by Swasti and Oxfam detailed in section 4.7 below and one by ANP+ looking at PLHIV after the Tsunami.[33] It also raises migration as a key compounding factor in vulnerability increase.

The IOM report on how migrants were affected by the Tsunami looks at its effects of in Indonesia, Sri Lanka and Thailand, to examine the links between migration, development and natural disasters. The report details the migration patterns of the three countries, the damages incurred by the Tsunami, and the remittances that increased after the natural disaster. Some key points in the report have logical connections to HIV vulnerabilities around migration:

Changes in livelihoods

a. Pre-existing poverty
Even before the Tsunami an estimated 40% of the population in Aceh was living below the poverty line. Tsunami damage was estimated to be the equivalent of 97% of Aceh's Gross Domestic Product (GDP).[34] The underlying vulnerabilities associated with poverty, therefore, already existed but were deepened further.

b. Women hard hit
The hardest hit economically included small businessmen and women performing home-based work.[35] The fact that women were especially hit economically reinforced their vulnerability and, one can infer, eventual pressure to engage in risky behaviour to survive.[36]

c. Changes in skill sets needed
Many of those affected were fishermen, but the response for the fishing industry by the international community was short-lived and not always appropriate, leaving out those involved in support functions. This corroborates the comments from respondents interviewed that fishermen were forced to change their profession, and aid was not tailored for specific industries, or not tailored to the pre-existing skills of workers.

d. Remittances
The report does look specifically at remittances and how they increase after natural disasters. Although money was transferred via informal mechanisms, and exact amounts are not known, estimates are that remittances increased post-Tsunami. The study explains that pre-Tsunami remittances in Thailand and Sri Lanka in 2004 were almost as high as the damage estimates (2,198 million USD in Thailand and 1,454 million USD in Sri Lanka) and remittances to Indonesia were slightly higher than the damage estimates of 4,451 million USD.[37] Remittances tend to increase after a natural disaster, as explained in the report. Studies referenced in the report cite Bangladesh, the Dominican Republic, Haiti, Honduras and Pakistan as examples of countries where remittance flows increased following a natural disaster.[38] While the report here does not make the connection to HIV, it is clear that if remittances act to increase the income of a household and thereby sustain livelihoods after a natural disaster, then they are building resilience. The family or community is presumably then better able to weather the shock without having to resort to high-risk behaviours.

It would be interesting to study a household or community that received remittances from family members abroad after a shock such as a natural disaster. It would be worthwhile to look at factors such as: ability of such families to remain in or rebuild their homes and to keep their children in

[33] Please see IOM and synthesis reports.
[34] IOM, Migration, Development and Natural Disasters, p. 26.
[35] Migration, Development and Natural Disasters: Insights from the Indian Ocean Tsunami. IOM Migration research series, no 30, 2007, p. 31.
[36] This is not stated in the research, but an inference on the part of the author.
[37] Ibid., p. 48-49.
[38] Ibid., p 46.

school; changes in levels of sexual and gender based violence; and changes in levels of transactional sex and food security.

Special vulnerability of migrant

The report addresses migrant vulnerabilities after the Tsunami. HIV vulnerability was not the focus of the research but the conditions discussed below can all increase vulnerability to HIV.

a. Invisibility
Migrants are often hidden, and therefore the impact of disasters on migrants is not always reflected in the needs assessments or evaluations of aid. People post Tsunami literally lost their identities, meaning they lost their papers or identity cards, and became essentially undocumented displaced persons. They were therefore unable to unable to claim land or access essential services.[39] The governments redrew coast protection zones to discourage rebuilding along the shoreline, prohibiting some from returning to their homes, especially in Sri Lanka and Thailand. For example, in Sri Lanka, new construction within 100 metres of sea level was prohibited. Most of the 500,000 people living there before were forced to relocate permanently.

b. Migration to disaster sites
While internal displacement was rampant immediately after the Tsunami, the study concludes that migration out of the area for economic reasons was rare. What has been less studied is the phenomenon of migration ***to*** affected areas, either from family members providing support or reconstruction workers arriving. The affects of aid and reconstruction workers (international, government and migrants seeking income) in the immediate aftermath of a natural disaster bring accompanied risks in terms of contact with disease, difficult shelter situations as experienced by the displaced, and new modes of survival. While not the subject of this report, it can be inferred that the HIV vulnerabilities associated with migrant workers, such as time away from home, hubs of mainly unaccompanied men and opportunities for commercial sex work are potentially present in these post natural disaster reconstruction zones.

c. Contact with populations of higher HIV prevalence
Migration can of course bring populations with higher HIV prevalence rates into contact with others and potentially increase transmission risks. In the case of the Tsunami, the border between Myanmar and Thailand is one such place. The IOM report discusses the large number of Myanmarese migrants in Thailand. In 2005, the IOM estimated 120,000 people in refugee camps along the border, and many more economic migrants working in agriculture, fisheries and construction, rubber plantations, shrimp farms and the tourism sector, many of whom were living in shantytowns near piers or the shoreline. Hence this population suffered from displacement after the Tsunami and faced difficulties in accessing aid. In some cases, they were deliberately excluded from aid; in other cases, fear of arrest or deportation kept them from accessing aid and revealing their position.

The link that is not made in the report (and may warrant further attention in light of HIV vulnerability) is the growing rate of HIV in Myanmar. The situation has been described as "explosive" and HIV shelters for Myanmarese exist on the border in Thailand. Migration to Thailand and associated increased sexual activity ('sexual freedom') is cited as one of the reasons for the rising HIV prevalence rate.[40] Because of their illegal migrant status, many Myanmarese are not entitled to social services. One can presume that at least some of the affected migrants were PLHIV, meaning that the risk of transmitting HIV is/was present.

d. Children
While there was a fear on the part of international organizations of increased child trafficking following the Tsunami, prevention measures and awareness were heightened, and the IOM report found that there was not a noted increase in child trafficking. The Tsunami did leave a large

[39] Ibid., p 30.
[40] PlusNews 27 Nov 2007.

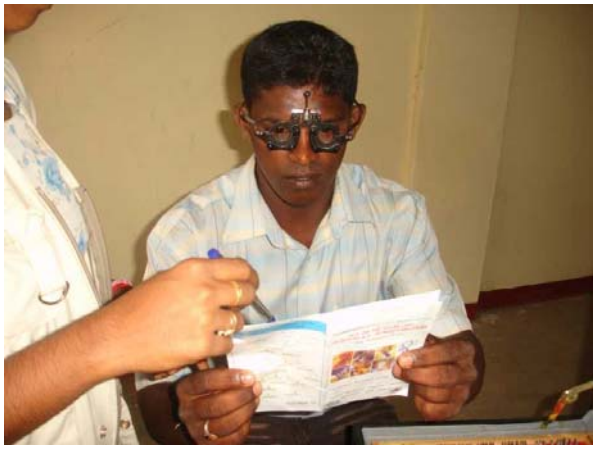
number of children unaccompanied: in Thailand there were a reported 1,172 orphans. The report also mentions the widespread practice of families finding and claiming children post-Tsunami.

This report also touches on some recurring themes in trying to gather information on post natural disaster vulnerabilities, including:

Lack of baseline data - in a review of the Tsunami response, indeed, one of the criticisms was this failure to differentiate between pre-existing or post-Tsunami needs.[41] Also, the number of people already internally displaced due to conflict in a place like Sri Lanka skews the post-Tsunami data on IDPs.

Need for cooperation amongst humanitarian workers and area specialists the report points to a need for better integration of humanitarian workers and other specialists. While HIV is not an identified area, it is clear that HIV needs to be integrated with humanitarian response. The report calls for coherence amongst three policies: migration, development and disaster response. The disconnect between disaster response and other polices has been mentioned in different ways throughout this research. This disconnect leads to the lack of preparedness and integration of HIV in the immediate emergency response.

Sri Lanka



Sri Lanka: Eye Care Program and HIV

In the response to the Tsunami, IOM was able to include HIV programming in its Eye Care Program after the Tsunami. The eye care program was quickly identified as an entry point to access target groups that are vulnerable to HIV (identified as Tsunami affected and low income) and provide them with HIV awareness material. Leaflets on HIV and AIDS education are given to each eye camp beneficiary, which they are able to read it while testing their new glasses.

India

<u>HIV vulnerability post Tsunami</u>

Swasti and Oxfam carried out a study on vulnerability to HIV in Humanitarian Emergencies in Tsunami affected communities in India. Amidst anecdotal evidence of increased vulnerability to STIs and specifically HIV after the Tsunami, and with the understanding that evidence on links between emergencies and the spread of HIV is limited yet needed, the authors set out to assess the impact of this natural disaster on HIV vulnerabilities of the affected communities. The authors carried out a literature review, inquiry (using social mapping, polling booths, interviews and risk mapping) and case studies in 30 locations in India to ascertain vulnerability to HIV, change in vulnerability to HIV due to the Tsunami, the current responses and the potential for mainstreaming.

The methodology of interviewing 1,100 people focused on vulnerability to four behavioural risk factors:

1. unprotected sex with non-regular partners;
2. exposure to infected blood and blood products;
3. sharing infected needles; or

[41] Migration, Development and Natural Disasters: Insights from the Indian Ocean Tsunami. IOM Migration research series, no 30, 2007, p. 28.

4. HIV transmission from mother to child.

Vulnerability also included causal factors such as knowledge about STI prevention, access to health services, cash flow, and alcohol consumption.

"Researchers assessed how vulnerable each of the villages was to these factors…and then determined whether and how that vulnerability had changed since before the Tsunami. Patterns related to housing (settlements of original homes, temporary shelters, and new permanent homes), to major sources of livelihoods (fishing, agriculture, and other activities), to degree of devastation (high or low loss of life), and to sub-populations (married and unmarried men and women) were all analyzed."

The assessment found that 29 of 30 coastal communities were vulnerable to HIV before the Tsunami. The Tsunami and its effects had raised vulnerability in at least two-thirds of the locations. The key factors in increased vulnerability are best summarized in a power point presentation by the authors:

Factors increasing vulnerability:

a) Physical proximity due to temporary / permanent displacement (increasing chances of interaction between opposite sexes)
b) Availability of 'safe spaces' for sexual activities
c) Sex for obligations, livelihood protection, Sexual harassment
d) Social controls breaking down
e) Less privacy, less spousal sex, sought elsewhere
f) Increased STIs – Particularly women, untreated
g) Displacement, mobility & migration - new environment, less protection
h) Brinkmanship/fatalistic attitude to sex and unprotected sex
i) Increased availability of compensation cash, particularly with single and younger persons – providing a platform for trying new things
j) Increased alcohol consumption, increased unprotected sex – commercial and non-commercial

Factors inhibiting vulnerability:

- Tighter than usual controls from strong traditional Panchayat (village elders governing behaviour)
  - Disincentives (such as fines, social isolation, forced marriages, etc.) for sex outside marriage and sexual abuse)
- Awareness about HIV built up/more information and education on HIV available.
- Increased love and arranged marriages post Tsunami
- Little or no leisure time
- Less access to safe places for sex with destruction of homesteads

A couple of points from the report are worth expounding on, as they have implications for emergency response. Namely, in the area of shelter, which was cited here as the key factor increasing vulnerability in these communities. The close proximity of the shelters and shelter design both contributed to vulnerability. Each family was housed in a single cubicle, not allowing for privacy between a married couple. "Many therefore looked for sex outside the home."[42]

Cash was given out as part of the disaster response, especially during the emergency and rehabilitation phases. The report explains that in some cases, the amount was high enough that people did not need to seek additional income. For some people, as reported in this study, this cash, coupled with more leisure time, resulted in cases in increased drinking and engagement with commercial sex workers.

[42] Swasti, Oxfam, p. 10.

The normal regulating bodies of social norms, the Panchayat, has already been cited as a factor reducing vulnerability. However, in one third of the communities studied, the Panchayat lost control over their communities due to displacement and dispersement. This is cited as one way in which social control broke down, and community members found themselves more “free” to engage in risky behaviour. Interestingly, this study found that married men and women were the most vulnerable subgroups. Unmarried women were least vulnerable. This is accredited to strict social controls and young marriage. This attests to the fact that social controls did not break down completely.

5. Conclusions

IOM is responsible for Camp Coordination and Camp Management (CCCM) under the cluster approach. This means that, while IOM can still contribute to humanitarian response in other sectors under humanitarian reform, the mandate of the organization is to lead on CCCM for natural disaster-induced IDPs. In responding to HIV, IOM faces constraints in mandate of the cluster approach as well as constraints in financing HIV programming through joint appeals; additionally, it’s staff capacity to respond to HIV in natural disasters (especially in low prevalence countries), is weak.

While IOM faces the same challenges as most organizations in data collection on HIV vulnerabilities, it does appear that in places such as Uganda, Zimbabwe and Somalia, data related to HIV vulnerabilities is beginning to be collected. The challenge now will be to determine what kinds of data are needed to measure impacts and to determine how additional vulnerabilities in a natural disaster can indeed be recorded, with the aim of being minimized. The baseline date being collected could be used to compare more recent situations and develop more focused information on HIV vulnerabilities.

In responding to HIV in Zimbabwe, IOM has focused on gender equity in aid. This is especially relevant as the research found exhibits an increase in women and girls’ vulnerability in light of Operation Murambatsvina and more recent politically-induced migration out of Zimbabwe. Transactional sex and potentially abusive relationships appear to have become two survival mechanisms for some female Zimbabwean migrants in South Africa.

The studies collected here drive home the added burden of being a “hidden” migrant. The cases of Zimbabwean migrants in South Africa and the complete loss of identity of many after the Tsunami due to lack of documentation both resulted in challenges in accessing shelter and health services, and the additional risks of exploitation that come with being ‘paperless.’ These migrants also suffer from stigma and discrimination, often exacerbated by xenophobia, language and cultural barriers. The challenge here is to understand how these vulnerabilities interact with pre-existing vulnerabilities for PLHIV or those at risk of exposure to HIV.

In the Zimbabwean context, IDP camps in Uganda, and in the response to the Tsunami, there is evidence that emergency response brings added attention to HIV. That added attention manifests itself in increased HIV services in areas that may not have had them before, such as new IDP sites. Increases in HIV and sexual and reproductive health services also appear, from this research, to be used by the communities.

Research in India after the Tsunami concluded that poor shelter design was a high contributor to HIV vulnerability. As well, the use of cash as aid led, in some cases, to an increase in commercial sex after the Tsunami. The same research also shows the role of local leaders in governing and maintaining social norms. The importance of trying to retain pre-disaster social order, therefore, has implications for shelter design in trying to keep community structures together.

Finally, more research may be in order around how remittances may reduce HIV vulnerabilities after a disaster. IOM research makes the case that remittances tend to increase in the aftermath of a natural disaster. The authors assert that this was the case after the Tsunami as well. The impacts of remittances on household resilience to HIV may warrant further attention.

6. Persons contacted/interviewed

Islene Araujo
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Jaime Calderon
IOM Indonesia

Rosilyne Borland
IOM Costa Rica

Sajith Gunaratne
Health Operations Coordinator, Migration Health Department
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Leo Kenny
UNAIDS Somalia
Nairobi, Kenya

Dr. James Wanyama
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Susan Cookson and Sapna Bamrah of the US-CDC who are doing a study on morbidity – including aspects of HIV & AIDS – in the Kenya Elections aftermath.

7. Documents reviewed

Addressing HIV Vulnerability and Service Needs of Zimbabwean Migrant Populations in Southern Asia, 27 February 2008 and 22 February assessment – confidential

Asmita Naik, Elca Stigter and Frank Laczko, Migration, Development and Natural Disasters: Insights from the Indian Ocean Tsunami. IOM Migration research series, no 30, 2007.

Assessment of Sexual and Reproductive Health Needs of People Living with HIV/AIDS in Bangladesh, Habib, UNFPA, July 2007.

AVAS presentation on sex workers and the Tsunami, power point presentation

Children Crossing Borders, Save the Children UK, July 2007.

CRIS Update Somalia, February 2008

HD Net, HIV and People on the Move: Risk and vulnerabilities of migrants and mobile populations in Southern Africa, 2006

IOM Assessment on Operation Murambatsvina: Impact on HBC support, chronically ill, OVCs, gender violence and family structures, November 2005 – confidential

IOM Regional Response to HIV and AIDS Among Vulnerable Cross-border Migrants in South Asia

IOM, Final report to DFID: Urban Displacements in Zimbabwe: Responses to HIV Vulnerability and Gender-Based Violence

IOM: Population Mobility and HIV/AIDS

Light at the End of the Tunnel: HIV Prevention for Colombia's Internally Displaced Youth. 2007, UNFPA and Margaret Sanger Center International at Planned Parenthood of New York City.

Mainstreaming HIV/AIDS within Humanitarian Assistance for Internally Displaced Populations: Lessons From Zimbabwe 2005-2006, Mumtaz Osman, June 2006

Makina, Daniel, Survey of the Profile of Migrant Zimbabweans in South Africa: A Pilot Study, University of South Africa, August 2007

OCHA/UNAIDS/UNICEF, AIDS and Humanitarian Action- Somali Stakeholders Workshop, Sarova Pan Afrique Hotel, Sept 27, 2007

Responding to Zimbabwean Migration in South Africa– Evaluating Options; Background document prepared by Forced Migration Studies Programme for a meeting on 27 November 2007 at the Chalsty Centre, University of the Witwatersrand, *Revised Version – 28 November 2007* hosted by Lawyers for Human Rights, the Wits Law Clinic, and the Wits Forced Migration Studies Programme.

Somali AIDS Response Newsletter, February 2008

N Shiv Kumar, N Raghunathan & Benoy Peter, Vulnerability to HIV in Humanitarian Emergencies: A Study of Tsunami Affected Communities in India (Swasti/Oxfam)
Study found at: http://www.oxfamamerica.org/newsandpublications/publications/research_reports/understanding-the-effect-of-the-Tsunami-and-its-aftermath-on-vulnerability-to-hiv-in-coastal-india

Power point presentation on the internet at:
http://www.icaap8.lk/programme_at_a_glance/track_d/downloads_ppt/MoOPD04/MoOPD04-06%20-%20Shiv%20Kumar%20N.ppt
Discussion of the article on Oxfam's website at:
http://www.oxfamamerica.org/whatwedo/emergencies/fieldstudies/news-publications/research-that-could-save-lives-hiv-and-the-Tsunami-disaster

More on Myanmar and HIV:
http://www.atimes.com/atimes/Southeast_Asia/HL02Ae02.html

http://www.plusnews.org/Report.aspx?ReportId=75535