International HIV/AIDS Alliance
Together to end AIDS

POZ SIDA

Case study

The HIV response in emergencies

Lessons learnt from the 2010 Haiti earthquake

A POZ Outreach worker in one of the IDP camps.

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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Unless otherwise stated, the appearance of individuals in this publication gives no indication of either sexuality or HIV status.

Cover photo: A POZ Outreach worker in one of the IDP camps © Alliance

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Summary

On January 12, 2010 a massive earthquake struck Haiti, affecting 3.5 million people. Even before this disaster, Haiti was considered a fragile and impoverished state with serious public health issues and a generalised HIV epidemic estimated at 2.2%.

What did the earthquake mean for people in Haiti living with HIV and those most at risk to it? Death and destruction on such a massive scale saw rescue and short-term survival prioritised over other needs, leading to enormous gaps in the HIV response. More than 1.5 million people were made homeless and the huge number of people moving into camps or provincial towns post-earthquake meant palliative care and ARV adherence were difficult to manage. It also saw HIV vulnerability and risk increase.

This case study examines the experience of Promoteurs Objectif Zerosida (POZ), an Alliance Linking Organisation working to reduce the impact of HIV, AIDS and other STIs in Haiti, during the aftermath of the earthquake. It asses the coordination between partners working on HIV and with the UN's overall emergency response, and identifies key learning to ensure valuable insights from local organisations such as POZ are better integrated in future post-emergency situations to better meet the needs of people most at risk to HIV infection. The report also assess gaps and unmet needs three years on from the earthquake, and finds that, despite a significant expansion of Haiti's health services beyond those in place before the disaster, many national organisations working on HIV are experiencing a reduction in funding, particularly on preventative work.

Key lessons

- Emergency planning needs to take account of the fact that people most at risk to HIV infection often become more vulnerable in times of emergency due to a lack of prioritisation of their needs.
- Mechanisms need to be established to enable emergency appeal funds to be channelled to the essential work provided by local organisations as these organisations can most easily access 'at risk' groups. (For example, carrying out peer engagement in camps for internally displaced people in order to by identify people living with HIV in need of antiretrovirals.)
- In countries with high prevalence rates, a specific HIV cluster or sub-cluster should be established during emergency co-ordination to ensure that HIV needs are not over-shadowed by other immediate needs.
- Emergency responses need to build on the knowledge and experience of national organisations. Language barriers also need to be taken into account.

The Alliance in Haiti

The International HIV/AIDS Alliance (the Alliance) is a global network of nationally based, independent, civil society organisations united by a common vision of a world without AIDS. The Alliance is committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Established in 1995, Promoteurs Objectif Zerosida (POZ) became an Alliance Linking Organisation in 2005.

Over the years POZ has helped create associations and networks of people living with HIV (PLHIV) and led innovative work on reducing HIV related stigma and discrimination. Its mission is to reduce the impact of HIV, AIDS and other STIs through community mobilisation and supporting PLHIV.

POZ provides communities with a range of services including medical, behavioural and sociocultural and helps improve PLHIV's chances of earning a good livelihood. It works through community mobilisation and peer support and with young people, PLHIV, and the general population.

POZ played an important role in the emergency response following the 2010 earthquake, working in camps for internally displaced people (IDPs) to reach key populations (KPs) most at risk to HIV infection and advocating on behalf of victims of sexual assaults. POZ formed short-term strategic partnerships with other organisations including Action Contre la Fai, Care, World Vision and Christian Aid to ensure the livelihood and nutritional needs of PLHIV were met.

From 2005 to 2008, POZ strengthened and raised the profile of PHAP+, the newly formed network of Haitian PLHIV.

POZ operates in Port-au-Prince, Cap Haïtien (North Department), Montrouis (West Department) and Jacmel (South East Department).

1) Background and context

Even before the 2010 earthquake, which struck Port-au-Prince and its surrounding areas, Haiti was considered a fragile and impoverished state. Emerging as the first independent black nation in 1804, Haiti has suffered two centuries of misrule, often attributable to international intervention. Its economy is largely dependent on international aid and remittances sent by its diaspora. Half of its population of 10.4 million[1] live in rural areas. Agriculture is the most important source of employment but has low productivity. Jobs in the formal sector are rare, and much of the economically active population works in precarious conditions in the informal sector. Haiti was placed twenty-second in the global fragility ranking of 2011.

Haiti faces serious public health issues due to lack of preventive and curative healthcare and limited availability of clean water, poor sanitation and inadequate nutrition. Maternal mortality remains a pressing concern, standing at 630 per 100,000 in 2006[2] with only one quarter (26%) of births overseen by health personnel compared to 94% across Latin America and the Caribbean region in total[3]. Respiratory infections, malnutrition, diarrhea and infectious gastroenteritis are among the leading causes of death amongst children[4]. There is a generalised HIV epidemic with prevalence rates estimated at 2.2%.

[1] Estimate for 2012, Institut Haïtien de Statistique et de l'Informatique, consulted at http://www.ihsi.ht/produit_demo_soc.htm
[2] EMMUS-IV
[3] UNDP, consulted at http://www.ht.undp.org/content/haiti/fr/home/mdgoverview/overview/mdg5/
[4] Haiti UNGASS progress report, 2010

National health provision is extremely limited. Although gradually increasing, only 6.9% of the budget goes towards health expenditure (US Embassy, 2012[5]). Health services tend to be heavily concentrated in Port-au-Prince and larger towns leaving people in rural locations with little coverage. Many people tend to use traditional healers and come to health services only as a last resort and when treatment can be more difficult.

Chronic and widespread poverty drive the HIV epidemic and restrict the national response.

HIV prevalence and historical trends in Haiti

HIV prevalence is estimated at 2.2% (EMMUS-IV, 2005-6). In recent years, data suggests that the epidemic, while generalised, has stabilised.

- The number of PLHIV is estimated at 120,000, 13,000 of whom are aged 14 or under. Only two thirds of PLHIV know their status.
- 40% of PLHIV do not adhere to treatment6.
- There are approximately 87,000 AIDS orphans7.
- There is a gradual trend towards the feminisation of HIV.
- More than one third of all new HIV cases are amongst 15 to 24-year-olds. Rates are highest in the northeast (3.9%), the northwest (3.2%) and in urban areas (2.4% as opposed to 2% in rural areas).
- Recent data indicates high prevalence rates among men who have sex with men (MSM) (18.1%) and sex workers (8.4%)[8], although these studies may not be fully representative.

Stigma and discrimination drives HIV and acts as a major obstacle in reaching PLHIV. Discriminatory attitudes have particularly serious repercussions in health facilities where the lack of confidentiality deters many people from seeking treatment. However, current health policy seeks to integrate prevention, care and treatment for communicable diseases into regular service provision. This enables HIV services to reach groups who previously had less access.

Virtually all funding for the Haiti's HIV response comes from the US President's Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the latter of which provides 43% of funding. Global Fund money is managed by the United Nation's Development Programme (UNDP). PEPFAR is managed from the US Embassy and invests over US$100m a year in a diverse programme covering care, treatment, prevention, governance and health system management. Both the Canadian and French governments have shifted money away from HIV to other health areas. Funding from the Haitian government for the national HIV response is very limited

[5] The US is by far the largest donor, having pledged US$1 billion at the 2010 donor conference. Other major donors include Brazil, the World Bank, Canada, France, Venezuela and the American Red Cross

[6] *Considérations sur la prévention du VIH dans le cadre des interventions des SR du Forum* (mimeo) produced by the Forum de Lutte Contre le VIH/SIDA, la Tuberculose et le Malaria

[7] UNAIDS, consulted at http://www.unaids.org/en/regionscountries/countries/haiti/

[8] National serological and behavioural study by PSI

2) The 2010 earthquake

On January 12, 2010 a massive earthquake struck Haiti, its epicentre 15 miles from Port-au-Prince. The earthquake affected 3.5 million people. In its immediate aftermath,

- An estimated 220,000 died
- More than 300,000 were injured
- 1.5 million became homeless, including 600,000 in Port-au-Prince
- 60% of government and administrative buildings, 80% of schools in Port-au-Prince and 60% of schools in the South and West Departments were destroyed or damaged. Many health facilities, including the capital's main hospital, were destroyed
- Headquarters of the UN Stabilisation Mission in Haiti (MINUSTAH) collapsed, killing many including the mission's chief.

Rescue efforts in the immediate aftermath

- Survivors extricated the living and the dead from the rubble.
- The UN, the International Red Cross movement and other international organisations focused on bringing emergency assistance to victims.
- The Dominican Republic (DR) was the first country to give aid to Haiti, sending water, food and heavy lifting machinery. Two days later, more than 20 countries had sent personnel, medicines, materials and other aid.
- Within two days around 1,000 bodies were placed on the streets in need of burial.
- Within four days, hospitals close to the border with the DR were full. The DR said those crossing the border were allowed to stay but only temporarily.
- Hundreds of thousands of people, including many living with HIV, began living in makeshift camps in appalling conditions.

Tents in one of the many refugee camps after the earthquake of January 2010

Initial challenges and complications

- A huge influx of international humanitarian organisations, not least in the health sector, proved challenging for the state to coordinate.
- Confusion over who was in charge, air traffic congestion and problems with the prioritisation of flights complicated early relief work.
- Treatment of the injured was hampered by the lack of hospital and morgue facilities. A shortage of health facilities and personnel, who had either died or fled, limited healthcare provision (e.g. there was only one hospital operating in the capital one day after the earthquake).

After the emergency phase

On 22 January, ten days after the earthquake, the emergency phase of the relief operation drew to a close. The next day, the government called off the search for survivors. Supplies, medical care and sanitation became priorities. Delays in aid distribution led to angry appeals from aid workers and survivors, and looting and sporadic violence broke out.

In the face of more pressing emergency needs HIV was not considered a priority. Despite this, most of the institutions engaged in the HIV response managed to re-establish their operations relatively quickly.

Between October 2010 and May 2011, less than 10 months after the earthquake, Haiti was gripped by cholera. According to the US Centres for Disease Control and Prevention (CDC), the outbreak was the worst since the 1994 Democratic Republic of Congo epidemic. By August 2013, it had killed more than 8,230 Haitians and hospitalised hundreds of thousands more. In this context, PLHIV were not considered a major priority.

National organisations working on HIV had suffered major losses, losing staff and premises. POZ's senior management team and most programme staff survived. One staff member and three peer educators lost their lives; others were seriously injured. POZ also lost its buildings in Port-au-Prince including its administrative and service centre, Centre d'Espoir. As these were rented premises and POZ did not own the land on which the buildings had stood they were unable to access funds to reconstruct premises. Rental prices became exorbitant. SEROvie, Haiti's largest organisation serving gay and transgender people with HIV, was also devastated by the earthquake and its premises destroyed.

POZ's makeshift service centre after its buildings were destroyed in the earthquake.

Shortly after the earthquake, the Ministry of Public Health and Population and UNAIDS estimated that fewer than 40% of PLHIV had accessed antiretroviral therapy (ART) sites. In many instances, HIV services were being provided in the yards of health centres or hospitals. There were shortages of ARVs and tuberculosis drugs. The logistical management and distribution of drugs used for prophylactic treatment was poor. In many institutions, hygiene and medical waste management were problematic.

Impact on PLHIV

Most of the structural damage from the earthquake occurred in three geographical regions, Ouest, Sud-Est and les Nippes, home collectively to nearly 60% of PLHIV in Haiti. PLHIV on treatment need to take ARVs without interruption and with enough food. Yet the collapse of infrastructure affected access to food, water and essential medication such as ARVs. Most PLHIV were not open about their status due to discrimination. Confidential services and peer support were very important[9] in this context. However, community support mechanisms providing these services were broken, destroyed or severely strained.

PLHIV living in Port-au-Prince and the surrounding areas of Delmas, Pétionville, Carrefour and Léogane were all affected. Usual PLHIV support centres and safe spaces had been demolished, the majority of hospitals destroyed; those that were functioning were overwhelmed with injured people. Despite this, POZ and other local organisations organised themselves to provide support to those PLHIV who sought out their services.

The earthquake's long-term impacts

2012: Two years after the quake	2014: Four years after the quake
• A UN report found only 43% of money pledged for reconstruction projects had been committed. Venezuela and the US, promised a large part of reconstruction funds, but disbursed only 24% and 30% respectively. Japan and Finland are among the few donors to have fully met their pledges. • In 2010 and 2011, donors disbursed just US$108 million of the US$315 million in grants allocated to health projects. • **Only 6% of bilateral aid for reconstruction projects has gone through Haitian institutions. Less than 1% of relief funding has gone through the Haitian government.** • A January 2012 Oxfam report found that half a million Haitians remained homeless, still living under tarps and in tents.	• Oxfam (Jan 2014) reported that major challenges remain (echoing a report from June 2013 estimating 280,000 living in camps)[1]. • A UN report finds 817,000 Haitians still need humanitarian assistance due to poor living conditions and the risk of forced evictions from 306 camps. • Food insecurity, malnutrition, and the cholera epidemic exacerbate humanitarian needs. • The cholera epidemic persists as a significant public health crisis. Haiti now hosts half of the world's suspected cholera cases. • 89% of displaced people have left the camps and cholera incidence has dropped to 50%. • The abilities of the Haitian authorities to coordinate humanitarian aid in emergencies have also improved.

[9] UNAIDS Fact Sheet '*Conflicts and disasters contribute to the spread of HIV/AIDS*'. August 2003. http://data.unaids.org/Topics/Security/fs_conflict_en.pdf

3) The experience of national organisations

Rescuing survivors, caring for the injured, finding accommodation and food and burying the dead were the priorities after the earthquake.

The Haitian government had little capacity to respond to such a huge disaster. One year on, recovery was at a standstill. Only 5% of rubble had been cleared and only 15% of the required temporary houses built[10].

After the initial rescue period, national organisations such as GHESKIO, FOSREF and POZ and international organisations with a strong presence and history in Haiti such as Partners in Health, Action Against Hunger and Care stepped in to provide health services where they could. Women and children were considered a priority by all.

POZ began operating from its training centre within two weeks of the earthquake with clients continuing to seek services in the tented facilities. GHESKIO[11] provided specialised medical services for PLHIV including ARVs. Crucially, POZ coordinated with other NGOs to ensure non-duplication and appropriate coverage. The Ministry of Health developed an interim emergency response to set new priorities for the post earthquake period. This gave guidelines on interventions in IDP camps; strengthening the availability of medical supplies, ARVs and drugs for PLHIV and displaced people; psychological and economic support services. A round table of NGOs working on HIV was established to discuss problems and resolve issues but coordination was weak. POZ formed short-term partnerships with organisations including Action Contre la Faim (nutrition for PLHIV), Care (enabling PLHIV to re-establish livelihoods) and World Vision/Christian Aid (nutrition).

[10] From relief to recovery: Supporting good governance in post-earthquake Haiti. 6 January 2011, Oxfam
[11] A Haitian NGO dedicated to clinical service, research, and training in HIV/AIDS and related diseases. The health care provided by GHESKIO is of a very high standard and is free of charge, including services and medications.

POZ's response

A POZ Outreach worker in one of the IDP camps

- Focused on work in the IDP camps through trained community leaders and champions working with KPs most at-risk to HIV infection.
- Worked closely with organisations in charge of the camps, particularly in relation to sexual assault and rape.
- Diverted some of its existing (development) funding to its emergency response through good relations and negotiation with existing donors including CDC, the Alliance/Big Lottery Fund (BLF) and ICCO. Donors were flexible, enabling POZ to divert resources for work in the camps. Some donors visited the earthquake site and gave short-term support to POZ to replace equipment and lost materials, enabling POZ to start operating again.
- POZ approached many international actors seeking support but did not receive any funds from international appeals. This is reflective of a situation, reported by the UN Office of the Special Envoy for Haiti[12], where less than 0.6 % of funding from bilateral and multilateral donors has gone directly to Haitian organisations and businesses following the earthquake.

Learnings

Although the UN set up clusters around specific themes, and despite advocacy from POZ, no group was established for HIV. It is essential that a specific HIV cluster be established should future emergencies arise in settings with high prevalence.

Like most organisations in Haiti, POZ was not prepared for the disaster and the challenges it brought, and did not have an emergency preparedness and response plan. The humanitarian NGOs that arrived after the earthquake had ample staff and money to rent premises and provide services but did not do this through local organisations and do not have the expertise of local organisations such as POZ in working with key populations. Should future emergencies occur, supporting national NGOs who can access key populations would be crucial.

[12] Can more Aid stay in Haiti and other fragile settings? How local investment can strengthen Governments and Economies

4) Good practices, lessons learned

During the first three months after the earthquake the UN worked collectively through the UN Joint Team. It provided significant support for the post-disaster response, mostly through NGOs, by carrying out a post-disaster needs assessment (IOM, OCHA, UNFPA, UNAIDS) and supporting information, sensitisation and condom distribution. It also advocated for health and education to be included in post-disaster responses.

Humanitarian organisations that arrive in a country due to an emergency situation are not always familiar with that country's epidemiological situation, which can be challenging for on the ground operations. Language barriers and a lack of knowledge on how to reach certain groups such as MSM can also hamper activities. The problems wrought by language barriers surfaced during initial UN cluster meetings in Haiti. For a long time, these meetings were conducted in English rather than French or Creole, which contributed to excluding Haitian CSOs from the process. It is important that future emergency responses are planned using local knowledge and work with people in local languages.

Learnings

- POZ was not sufficiently positioned as a key stakeholder in the HIV response following the earthquake. This continues to cause problems for the resourcing of the organisation.
- Haitian civil society felt strongly that effort made by the UN to engage with local civil society organisations in the DR and Haiti was insufficient.
- International organisations are now withdrawing yet there are concerns that national facilities will be unable to cope.
- During an emergency response the international community should place more emphasis on building sustained local capacity by funding programmes that are locally owned and led, channelling funds through local institutions and better involving local organisations in disaster preparedness

5) Gaps, unmet needs, missed opportunities

The SPHERE standards[13] note that mass displacement may boost HIV vulnerability and risk due to separation from family members, plus the breakdown of community cohesion and norms regulating social and sexual behaviour. In Haiti, formal and informal sex work increased as women resorted to transactional sex to survive. HIV prevalence in camps was found to be double the rate than that of surrounding area. However, the most recent EMMUS V survey finds national HIV prevalence to be stable at 2.2% (EMMUS-V, 2012). Additionally, Haiti is a source, transit site and destination for adults and children subjected to forced labour and sex trafficking. Women and children living in IDP camps are at increased risk of sex trafficking and forced labour[14].

What could POZ have done differently?

After the earthquake many people from KPs found themselves without resources and often living in provisional shelters without family support. With hindsight, POZ regrets not getting actively involved in advocating for the needs of PLHIV and other most at-risk populations with those making decisions on reconstruction priorities. Again, with hindsight, POZ could have paid greater attention to ensuring that clinical services for KPs were prioritised and that psychosocial support and counselling available for KPs and staff of local civil society organisations.

Gaps in the response

The massive number of people moving into camps or provincial towns post-earthquake meant palliative care and ARV adherence were difficult to manage. The gaps in the HIV response were enormous due to priorities around survival and rescue.

There was very little coordination amongst partners working on HIV. There were some notable service gaps around surgery, psychological support, water distribution food and camp organisation. Despite the essential role it could have played, POZ's involvement was limited as it was not seen as an actor in the humanitarian response and could not access the emergency funds needed to effectively support KPs during the crisis.

Despite many challenges and a reduced amount of funding, POZ was able to reach out to PLHIV and MSM groups and provide ARVs and psychological support through outreach services.

[13] http://www.sphereproject.org/handbook/
[14] CIA Factbook, 2012

Learnings

- POZ could have been more involved with reconstruction to ensure KPs were prioritised. It also regrets not paying more attention to clinical services for KPs.
- National organisations offer valuable insight and could play a key role post-emergency.
- There was a lack of focus on HIV within the emergency response.
- There is a need to strengthen the position of local NGOs as key stakeholders in Haiti's HIV response.
- It is crucial to establish an HIV cluster group in any future emergencies to ensure gaps in service delivery do not reoccur.
- As poverty increases so does transactional sex. It is important to ensure Alliance Linking Organisations are well placed to establish a sub-regional HIV service network for refugees coming from neighbouring countries.

6) Current situation, future priorities and needs

Three years after the earthquake, Haiti's health services have expanded far beyond those in place before the disaster.

Status of health services for HIV

- HIV testing of pregnant women has increased by 55% from 129,840 in 2010 to 201,454 between October 2011 and September 2012. The proportion of pregnant women with HIV given ARVs increased from 54% to 83% during the same period.
- Access to ART rose from 35% of eligible patients in July 2009 to 69% in Sept 2012.
- In December 2011, 165 centres were offering VCT, carrying out an increased number of HIV tests[15] although rural areas remain relatively underserved.
- 58% of eligible adults and children have access to ARVs through 56 sites[16].
- Funding for STI treatment has fallen[17]. This is of some concern given the association between STIs and HIV.

Future priorities and needs

- Many national organisations working on HIV have experienced a reduction in funds financial capacity post-earthquake.
- Funding cuts over the past two years have fallen heavily on preventive activities, raising serious concerns that positive progress may be reversed.
- Despite the government's political will, funds for a national HIV response are limited[18].
- Haiti is a priority country under the new funding model of the Global Fund and is going through its country dialogue stage. Under the new funding model the country must budget for its national response including prevention work and resources for the vital work of local civil society organisations.
- Local organisations are often sub-recipients on large projects, and are unable to cover core costs.
- There is ongoing need for capacity strengthening in terms of emergency preparedness and response.

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[15] MSPP, 2012
[16] Figures for 2011, MESI consulted at http://www.mesi.ht/index.aspx
[17] Gap analysis carried out by the NGO Forum (mimeo).
[18] According to the Global Health Observatory Data Repository a mere 9.9% of the government budget is spent on health

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