Scoping Paper on National HIV Response in Emergency Settings in Mozambique:

Utilizing Case Studies from Gaza and Zambézia

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unicef

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LIST OF ACRONYMS

ART	Antiretroviral Treatment
C4D	Communication for Development
CBO	Community-based Organization
CCCM	Camp Coordination and Camp Management
CLGC	Local Disaster Risk Management Committee
CNCS	National AIDS Council
CSO	Civil Society Organization
DRM	Disaster Risk Management
FFA	Food for Asset
FGD	Focus Group Discussion
GAAC	Grupos de Apoio à Adesão Comunitária/Community Support Groups for Treatment Retention
GAM	Global Acute Malnutrition
GBV	Gender-based Violence
HCT	Humanitarian Country Team
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IASC	Inter-Agency Standing Committee
INGC	Instituto Nacional de Gestão de Calamidades (National Institute of Disaster Management)
IOM	International Organization for Migration
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NFI	Non-food Item
NGO	Non-governmental Organization

PEP	Post-exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
RCO	Resident Coordinator Office
SGBV	Sexual and Gender-based Violence
STI	Sexually Transmitted Infection
TAC	Temporary Accommodation Centre
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	(Office of the) United Nations High Commissioner for Refugees
WHO	World Health Organization
WFP	World Food Programme

PREAMBLE

The intent of this scoping paper is to provide baseline information related to HIV and emergencies in Mozambique, which could guide decision-making regarding how HIV is addressed throughout the duration of interventions within emergency settings in the context of Mozambique. The scoping paper is not research, but a joint effort of the International Organization for Migration (IOM), UNICEF, the National Institute of Disaster Management (Instituto Nacional de Gestão de Calamidades (INGC)) and the National AIDS Council (Conselho Nacional de Combate ao HIV/SIDA (CNCS)) to explore this issue. Although this paper is not research, the consultant applied principles of research to guide the approach taken when discussing issues with key stakeholders and local communities.

EXECUTIVE SUMMARY

Introduction

The overall objective of this paper is to generate evidence on HIV vulnerability, prevention and treatment needs among migrants and internally displaced persons (IDPs) in selected districts in Mozambique where one or more humanitarian emergencies have been recorded in the past five years. The Inter-Agency Standing Committee (IASC) guidelines for addressing HIV/AIDS in emergency settings were the framework used to guide this paper.

These are the paper's specific objectives:

1. To describe the impact of emergencies on people living with HIV (PLHIV);
2. To describe current emergency planning and emergency practices;
3. To offer recommendations for integrating HIV within emergency preparedness and response.

This paper looks at the scope of HIV/AIDS response in emergencies. Essentially it asks the question: How is HIV/AIDS managed and addressed during emergencies in Mozambique? This scoping paper focuses on: (i) the impact of emergencies on the risk of HIV transmission and on the ability of PLHIV to cope with the impacts of HIV and AIDS; and (ii) the effect of emergencies on health and other basic HIV-related services. Gaza and Zambézia provinces were the geographically selected areas, which are both prone to cyclical and reoccurring disasters and have HIV prevalence rates of 24.4 per cent and 15.1 per cent, respectively (INS and INE, 2017).

Method

For the development of this scoping paper, qualitative methods were mainly used to gather information. Field visits to the affected communities included representatives from government (i.e. INGC and CNCS) and representatives from UNICEF and IOM. With the support of a team, individual interviews and focus group discussions with HIV activists and other stakeholders – including civil servants; non-governmental organization (NGO) representatives; provincial, district and municipal government representatives; and representatives of donor organizations – were conducted. Interviews also included at-risk groups and people living with and affected by HIV, district administrators, community leaders, provincial and district focal points from

the INGC and the CNCS, appropriate committees and associations, and members of the selected communities that were affected by past emergencies.

Key Findings

- HIV is not included in current disaster and emergency management structures. Where there has been inclusion, such as during the 2013 floods, evidence indicates that the inclusion was late and not integrated within the humanitarian planning.
- There is limited evidence of the inclusion of the IASC guidelines for addressing HIV in humanitarian settings both within the humanitarian community (the Humanitarian Country Team (HCT)) and at the government level.
- PLHIV are left out during humanitarian interventions as a result of lack of integration of HIV/AIDS into humanitarian programming and because of HIV stigma.
- Humanitarian crises in Mozambique, including conflicts, not only heighten mobility (migration) and increase vulnerability to HIV transmission but also disrupt adherence to HIV care and treatment services.
- Evidence shows that food insecurity crisis, heightened by insufficient provision of food aid at the temporary accommodation centres (TACs) and limited access to food post the emergency response period, affected adherence to treatment and retention and resulted in deaths in a number of occasions.
- Displacement and loss of livelihood during emergencies lead to increased transactional sex among women and young girls, thus increasing exposure to HIV infection.
- Elementary trained polyvalent agents of health (APEs), community support groups for treatment retention (grupos de apoio à adesão comunitária (GAACs)), and other local HIV/health community-based groups play a key role in providing prevention and continuity of care and treatment services for at-risk groups and PLHIV during emergencies.
- Limited protection services in humanitarian preparedness and response during emergencies were shown to subject vulnerable groups (e.g. women, girls, orphans and vulnerable children, street children) to exploitation and sexual abuse. In addition, cultural norms and beliefs interfere with the reporting and management of sexual and gender-based violence (SGBV) and rape cases.

- "In the tented camps, where the delivery of health services operated, the health staff designated one line specifically for HIV positive people. They would shout out – 'all HIV positive people line up here' or 'the HIV line is that one'. There are many reasons why people do not want to disclose their status. They might be public servants, they may not have told their spouse of their status…and, as a result, people did not choose to get HIV services during this time due to this constraint." (Representative of a UN agency)
- Unavailability of post-exposure prophylaxis (PEP) services limits response capacity for victims of sexual abuse during emergencies.

Conclusion

Key findings demonstrate that HIV, although recognized as a general development issue in Mozambique, is not placed as a priority for emergency contingency planning. The lack of prioritization of HIV/AIDS throughout the humanitarian programming cycle has resulted in a clear institutional absence of the IASC guidelines for addressing HIV in humanitarian settings. These guidelines are essential to assist humanitarian actors to deliver a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises (IASC, 2010). In humanitarian response, particularly food insecurity crisis, provision of adequate and sufficient food rations both at the TACs and resettlement camps can support continuity of treatment adherence and retention of PLHIV.

The lack of inclusion of HIV in emergency planning may increase the risk of transmission during the acute phase of the emergency. The ability of communities to respond to and recover from emergencies is heavily linked to their resilience. Hence, ensuring access to prevention, treatment, care and support services to people affected by emergencies are prerequisites to building community resilience to disasters.

Recommendations

Government

- Government to prioritize the inclusion of HIV/AIDS in the Government's emergency and disaster management structure as a permanent pillar for emergency and identify concrete and practical interventions to be included in the 2017–2018 national contingency plan.
- The INGC and the Ministry of Health (MoH) to promote systemic integration and adoption of the IASC guidelines for addressing HIV in humanitarian settings. This starts with the inclusion of HIV as a critical pillar and function of emergency preparedness and response planning in the national contingency planning.

- The HCT or the Resident Coordinator Office (RCO) to provide overall leadership, coordination and support for an integrated multicluster approach to addressing HIV in emergencies through the adoption of key actions from the IASC action framework.

Clusters

- The Health Cluster should strongly promote and advocate, under the leadership of the World Health Organization (WHO), the systemic adoption and application of the IASC guidelines for addressing HIV interventions in emergencies. This will require integration of the IASC guidelines into the humanitarian programming and capacity development of local communities and organizations on the use of the guidelines.
- The Nutrition and Food Security Clusters, under the leadership of UNICEF and the World Food Programme (WFP), to give adequate attention to HIV in emergency settings. This includes ensuring access to adequate food and nutrition for PLHIV in TACs and resettlement camps, and assessment of the nutrition status of PLHIV to ensure the delivery and customization of appropriate interventions.
- The Protection Cluster to ensure the mainstreaming of protection and GBV throughout the emergency programming life cycle. Use early warning systems and GBV early warning indicators to improve emergency response and planning for HIV in emergencies. This may include setting up of a surveillance system that is sensitive in capturing the impact of drought/flooding on access to care and treatment services, including adherence to antiretroviral treatment and incidents of GBV.
- The Protection Cluster to strengthen protection services within camp coordination and camp management (CCCM) to prevent human rights violations against PLHIV during humanitarian interventions, particularly but not limited to stigma and discrimination.

Agencies

- UNICEF to continue to support and further strengthen community capacity in providing HIV/AIDS-related prevention and treatment services by building on the work of APEs and scaling up mobile brigades to include HIV in emergency planning and response.
- The United Nations Population Fund (UNFPA) to lead government support to ensure the ready provision of PEP kits in order to address occupational and non-occupational exposure, particularly in CCCM.
- IOM to continue to build the decentralized capacity of the government, partners and communities in CCCM.

1. INTRODUCTION

1.1. Background

Mozambique is located in one of the three regions of Africa most exposed to the impact and influence of extreme events such as cyclones, floods, droughts, epidemics and earthquakes. It ranks among the most disaster-prone African countries (MAEFP, 2015). In the last decade, the frequency of disasters in Mozambique has doubled (INGC, 2013) with cyclical and reoccurring floods, cyclones and droughts, in addition to epidemics (e.g. HIV). The repetitiveness of these natural disaster events, combined with other emergencies such as the HIV epidemic, is a constant reminder of the complexity of the Mozambican landscape for humanitarian response and development.

According to the literature, HIV and emergencies have a unique interaction. The factors that determine HIV transmission during humanitarian emergencies are complex and depend on the context and overall response strategy. Existing gender inequities may be amplified, making women and children disproportionally more vulnerable to HIV. The loss of livelihood and the lack of employment can result in an increase in sex work and sexual exploitation. Mass population displacement may lead to family separation and the breakdown of social structures and norms that regulate behaviour.

Food insecurity for people living with HIV (PLHIV) may affect treatment adherence, having an impact on their success at staying healthy while living with HIV and, in some cases, may result in death. Therefore, it is important to address the various interactions that fuel the vicious cycle in which HIV can propagate as a result of various interplays, including negative coping mechanisms, which increase the risk of exposure to HIV and require integrated interventions and coordinated approaches.

HIV prevalence in the country sits at 13.0 per cent (INS and INE, 2017). Gaza and Zambézia provinces, where the study focused geographically, are prone to cyclical and reoccurring disasters and have HIV prevalence rates of 24.4 per cent and 15.1 per cent, respectively. It is important to note that while Gaza and Zambézia register high HIV/AIDS prevalence, these provinces are also the most prone to natural disasters in the country. In Gaza, recent examples include the 2013 floods and two years of consecutive drought (2015–2016) resulting from the strongest El Niño drought conditions in 35 years. Whereas, in Zambézia, examples include the recurrent floods that isolated the province in 2014; the military conflict in 2015 that

blocked off access to health clinics, making it difficult for PLHIV to access treatment; and the El Niño-induced drought.

The results of the 2016 food security and nutrition assessment of Mozambique's Technical Secretariat for Food Security and Nutrition (SETSAN) indicated severe acute levels of malnutrition in Zambézia province, with projections of serious deterioration of the nutrition crisis for Gaza province. Table 1 shows the global acute malnutrition (GAM) rates in the two aforementioned provinces.

Table 1: Global Acute Malnutrition Rates in Zambézia and Gaza

Province	Global Acute Malnutrition Rate by Mid-Upper Arm Circumference (%)	Estimated Number of Cases
Zambézia	9.1	73,466
Gaza	2.1	4,967

Rationale

The rationale for this paper is to understand the scope of the management of HIV/AIDS during emergencies in Mozambique to ensure adequate support to prevention, treatment and care services for PLHIV during and throughout the humanitarian intervention life cycle.

1.2. Structures

The National Institute of Disaster Management (Instituto Nacional de Gestão de Calamidades (INGC)) was established in 1999, and is the leading government institution mandated to coordinate disaster risk management (DRM) efforts in Mozambique. It operates under the Ministry of State Administration and Public Function and coordinates all efforts and an array of activities to promote disaster prevention at the national, provincial, district and community levels through a range of institutional arrangements.

Under the current DRM structure, cyclones and droughts are monitored and managed in three separate regional emergency operation centres. Droughts are monitored in Vilankulos, floods in Caia and cyclones in Nacala. There are four multiple-use resource centres at the district level which specialize in reducing vulnerability to droughts. In addition, the INGC acts through local disaster risk management committees (CLGCs), which serve as decentralized offices to support community disaster preparedness and resilience efforts. However, the lack of

capacity and lack of access to ongoing training and resources put considerable strain on their effectiveness in strengthening community preparedness.

Mozambique has a multisectoral response to HIV/AIDS. The main agencies involved are the Ministry of Health (MoH) and the National Council to Fight HIV/AIDS (Conselho Nacional de Combate ao HIV/SIDA (CNCS)). The CNCS coordinates HIV/AIDS response actions, with particular focus on prevention and community-led interventions by civil society organizations (CSOs), while the MoH concentrates mainly on HIV testing. Both of these entities are supported by the government and donor community with resources and technical support, as well as international non-governmental organizations (NGOs), such as FHI 360, and community-based organizations (CBOs), such as N'weti, to support the first goal of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 framework.[1] However, despite rhetoric suggesting coordinated efforts (PEN III, 2010–2014), the CNS and the MoH are uncoordinated and poorly aligned. The current spread of the epidemic, mainly among women, and its ominous impact, points to gaps between formal intentions and the efficient implementation of HIV and AIDS response plans and strategies in practice (PEN III, 2010–2014). Challenges persist in terms of functional coordination, the capacity of institutional structures and the alignment of priorities.

In terms of the harmonization of emergency planning and response planning with HIV/AIDS prevention, care and treatment, there are well-established institutions and working groups that are situated within their own pillars and respond to their mandates accordingly (Hald, 2013). For example, the Government has a permanent system that involves its established institutions (Conselho Coordenador de Gestão de Calamidades (CCGC), Conselho Técnico de Gestão das Calamidades (CTGC), INGC, etc.) and they work in collaboration with their partners such as the Humanitarian Country Team (HCT), which consist of various working groups and IASC partners. Within the United Nations cluster system, HIV falls under the Health Cluster (Hald, 2013), which, in Mozambique, is led by the World Health Organization (WHO) and co-led by the United Nations Population Fund (UNFPA), with strong support from UNICEF.

[1] By 2020, 90 per cent of those who are HIV-positive know their status, 90 per cent of all people with diagnosed HIV infection received therapy and 90 per cent of all people receiving therapy will have viral suppression (UNAIDS, 2017).

1.3. Objectives

The purpose of this paper is to expand current knowledge on the interactions between HIV, internally displaced persons (IDPs) and emergencies in Mozambique in order to inform practices and improve outcomes for people living with, affected by and at risk of HIV.

Specifically, the objectives of the paper are as follows:

1. To describe the impact of emergencies on people living with HIV;
2. To describe current emergency planning and emergency practices;
3. To offer recommendations for integrating HIV within emergency preparedness and response.

2. METHOD

Prior to data collection, a literature review was conducted. The CNCS, the INGC, IOM and UNICEF provided key policy documents, including after-action reports, situation reports, lessons learned, documents on humanitarian interventions, and national government contingency plans, in addition to other key documentation. More than sixty-three documents were consulted which provide the secondary data to augment primary data collection.

Primary data collection also included interviews with at-risk groups and PLHIV as a means to collect their experiences and perspectives into the problems affecting how HIV/AIDS is managed during emergencies and the impact of emergencies on PLHIV.

The IASC guidelines for addressing HIV in humanitarian settings were used to formulate relevant questions and assess institutional practices and policies for addressing HIV in emergencies. Both IOM and UNICEF provided their inputs in relation to the formulation of questions. Against the backdrop of the ongoing El Niño nutrition emergency response, the research integrated questions around nutrition to explicate what coping mechanisms are used by affected populations throughout the emergency food insecurity and nutrition crisis.

2.1. Sampling

The research employed purposeful and snowball sampling with key informants, through interviews and focus group discussions (FGDs). Key representatives from the CNCS and the INGC extended an invitation to provincial and local governments, NGOs, CBOs and local associations in both Gaza and Zambézia provinces to participate in the interviews and FGDs. An IOM representative extended an invitation to donors and international NGO contacts at the central level to participate as well.

Interviews with key informants, both individual and by group, totaled 445. Sixty-seven individual interviews were conducted and 378 individuals participated in FGDs. During the discussions, when appropriate, women were separated from men to address social and cultural considerations where women were often not permitted to speak. Interviews lasted 30 minutes and up to 2 hours.

2.2. Geographical Targeting

Field visits for this were undertaken in two provinces within Mozambique – Zambézia and Gaza – as these are the two most disaster-prone provinces in the country (see Table 2). Field visits to Zambézia commenced on 16–23 April 2016, and to Gaza on 8–12 May 2016. Chokwé and Guijá districts in Gaza province were chosen because of their high vulnerability to disasters, high frequency and high record of humanitarian emergencies, and high HIV/AIDS prevalence rates. In 2013, floods displaced more than 180,000 people in Gaza province, adding to the population of IDPs in existing IDP camps in Chaquelane and Xinhacanine in Chokwé and Guijá districts (UNRCO, 2015).

Table 2: Data Collection Summary

Province	IDP Camp	Type of Emergency	Rural District
Gaza	Chaquelane	Flood	Chokwé
	Xinhacanine	Flood	Guijá
Zambézia	Brigodo, Ronda	Flood	Namacurra
	Nacogolone, Matebe, Macuvine	Flood	Mocuba

In Zambézia, the districts of Namacurra and Mocuba were the focus. The districts have recently, and in the past, been affected by multiple shocks among which are floods and cyclones, resulting in humanitarian emergencies (INGC, 2013). Zambézia is also among Mozambique's provinces with the highest HIV/AIDS prevalence (INE, 2009).

In 2015, by March, in Zambézia province alone, floods had displaced more than 56,000 people in 10 districts (i.e. Mocuba, Maganja da Costa, Nicoadala, Namacurra, Morrumbala, Mopeia, Mocubela, Chinde, Luabo and Lugela) (IOM, 2015; INGC, 2013). In addition, and considering the current political and military tensions in the country, these districts are relatively safe and accessible.

3. FINDINGS

This section describes seven key areas that emerged during the course of data collection. Although the sites included in this paper were largely flood-affected areas, data was also gathered related to drought-affected communities and provinces, as many of the flood-affected areas overlapped with those affected by drought. A small group of participants was able to provide some additional perspective on the impact on HIV services and treatment needs in areas in Mozambique that have recently been affected by conflict. As stated previously, the IASC guidelines provided the framework for the analysis of this paper.

3.1. Government Disaster Management Structures and the Inclusion of HIV/AIDS in Emergency Planning

Overall, HIV was described as "absent" from emergency planning. However, participants at all levels described the need for HIV to be included as a pillar within emergency planning. While some participants from district government and community leader levels noted that this was the first time HIV had been brought to their attention in the context of emergency planning. "Systematic inclusion of HIV in emergency/preparedness planning and implementation of activities including reporting indicators is needed," noted by a participant. The views of participants were consistent in either supporting the need for greater inclusion and involvement of PLHIV and other vulnerable groups in disaster management or stronger representation at national disaster management forums/committees (e.g. CTGC and CLGCs), which clearly underscores the need for continued engagement with and inclusion of the IASC guidelines at both the government and HCT levels.

Another important finding at the planning level was in relation to the Health Cluster, which plays an essential part in humanitarian response. Participants explained that the health cluster system and the humanitarian interventions have not adequately incorporated the IASC guidelines, particularly in relation to food security, nutrition and livelihood support, protection against HIV-related human rights violations, provision of PEP and integration of HIV in CCCM.

> If the Health Cluster is not strong we miss the opportunity to advocate health issues, which is what we are seeing with the HIV response in emergencies.
>
> *(Key informant, Maputo)*

During an FGD regarding the Health Cluster, the participants pointed out that institutional memory has always been a problem with the UN system. When one lead leaves his/her position and is replaced by another, the history of previous work can be easily lost due to a number of circumstances. In the case of Mozambique, the transfer of information related to HIV in emergency settings is fragmented at best. This issue results in part from the lack of systemic knowledge management practices within institutions and also can be attributed to poor tracking to support the implementation of lessons learned from previous emergency response interventions, leading subsequently to fallacies of recollection about critical HIV interventions.

> The Health Cluster is weak; it is acting as an ad hoc committee at the moment, meeting when needed rather than having regular intended meetings. The Cluster has never tackled HIV as an issue in emergency as far as I know.
>
> *(Key informant, Maputo)*

As a result, the Health Cluster has missed the opportunity to advocate the incorporation of HIV, for example, into the national guidelines for emergencies. One UN donor representative explained:

> The health component is quite weak within the national emergency plan, and, as a result of this, the lack of attention for HIV, when HIV patients default, as well as TB resistance, becomes a huge issue.
>
> *(Key informant, Maputo)*

Therefore, HIV/AIDS is situated inside the Health Cluster, but it is not well articulated to respond to and reflect the actual situation. As one interviewee describes it:

> HIV is an afterthought, days later and in the case of Gaza, in 2013, it was at least a week late. It is not taken in the same weight as, say diarrhoea or cholera; however, the consequences are grave.
>
> *(Key informant, Xai Xai)*

Although participants understood that HIV in emergencies does not carry the same weight as cholera in the red-alert phase of an emergency, they asserted the need for response planning to provide special attention to HIV.

Attention to HIV, although late, did occur in the 2013 flooding in Gaza province. A draft document titled "Platform to Support the Mainstreaming of HIV and SGBV in Emergency and Recovery Settings" was developed after these floods as an attempt to incorporate the IASC guidelines into future planning efforts (UNFPA, 2013). Assessments and training programmes were carried out in both Gaza and Zambézia following the 2013 floods, first at the central level, then at the provincial level and some at the district level (with technical and leadership support from UNAIDS). A UNAIDS representative noted that although the training programmes were not sufficient to ensure HIV remained within the planning process, one district in Zambézia, that is, Morrumbala, was able to integrate HIV into its plan. The administrator of this district secured funds and requested UNAIDS to assist the

district in the integration. As well, the Zambézia Provincial AIDS Council (Núcleo Provincial de Combate ao HIV/SIDA) (2016) has developed a plan for HIV within emergency settings for the province of Gaza. Four days after developing the plan, the Council presented it for implementation, but the plan has not been implemented. The plan does not include biomedical interventions, such as the procurement of antiretroviral treatments (ARTs) and PEPs; however, it reflects the progress made as to the incorporation of HIV as an issue in emergency planning.

3.2. Risk of HIV and Sexually Transmitted Infections during Emergencies (Flood and Drought)

Participants noted that already existing HIV vulnerabilities are exacerbated during emergencies, exposing vulnerable groups to HIV. There was a recognition that negative coping mechanisms lead to transactional sex among young girls; they engage in sex in exchange for money, food, fish (e.g. in Mocuba) and non-food items (NFIs), especially after flooding and during droughts.

Risky sexual behaviour occurs due to separation of families mainly in the context of conflict and flooding, although it also happens in drought situations. Respondents said that during droughts, men would migrate with animals, leaving women and children behind with no source of livelihood. Men would migrate with their animals to sell them and they can engage in unprotected sex while the women who are left behind may engage in risky sexual behaviour for survival or by force. During the floods in Gaza, it was noted that a number of cases of sexual abuse and rape among women and minors occurred on the road to Chaquelane. One participant described a particularly disturbing case:

> “On the road to [the] Chaquelane accommodation centre, a young girl was raped. Many girls were abused actually, but this particular girl was badly raped, damaged. There was no counsellor for her; there was no PEP to prevent the transmission of HIV if the perpetrator had HIV. In the accommodation centres it was safe, but outside there was no security. It was a terrible situation. We were unprepared.”
>
> *(Key informant interview, Maputo)*

Due to separation of families, SGBV is left unchecked. Women and young girls encountered rape during the floods in Gaza, potentially exposing them to HIV and other sexually transmitted infections (STIs). Respondents in Gaza and Zambézia mentioned that the victims of rape will not report cases for fear of stigma and rejection, and, therefore, accurate numbers and cases are irretrievable but we know it happens.

In the province of Zambézia, during field visits, all communities denied cases of sexual abuse and rape. They did admit that transactional sex can occur, and GBV can also be a problem. However, the Mayor of Quelimane, Manuel Araujo, brought clarification to this point and explained the phenomenon this way:

> Of course sexual abuse and rape is a major problem, especially during emergencies. We all know this in Mozambique but no one acknowledges it, especially at a community level. The disruption of social norms that accompanies emergencies breaks down the social fabric and places women and girls at risk of multiple vulnerabilities and even men can fall victim to abuse. We had a recent case of this here in Quelimane where a man was abused. It is important that this is recognized and HIV is incorporated as a pillar in emergency planning.

Evidence from interviews indicated there were no well-defined plans at the community, district, provincial and central levels for emergencies that incorporate HIV risk that had already been implemented, except in the case of Morrumbala; however, access to this plan was not shared.

3.3. Access to Health and HIV-related Services

Throughout the data collection, it was repeated that existing health services were interrupted during flooding and access to HIV prevention, care, and treatment was disturbed due to many factors. During emergencies, PLHIV had difficulty accessing HIV services because of insecurity, poor road network (i.e. flooding seriously damaged roads and bridges), impassable roads and weakness due to lack of food as they had to walk long distances to service delivery points (Freedom House, 2016; United Nations Office of the Resident Coordinator, 2015). For example, the flooding destroyed some health centres (see photo below). Participants reported that these health centres had lost medicine, equipment and documentation, which resulted in lack of medications. Because of loss of documentation, ART retention monitoring was impossible to provide.

Although participants mentioned that HIV treatment and prevention awareness campaigns through social mobilization and key communication for development (C4D) messaging arrived in the TACs and resettlement camps, they reported that the response was late and not timely enough to ensure that PLHIV remained on uninterrupted treatment and that the people had access to information about voluntary testing and treatment that was in line with the IASC guidelines. This contributed to another gap in services in both provinces. One participant in Maputo described it this way:

> The preparedness of the system is not positioned to deal with HIV. We do not have a formal structure of pillar in place within the emergency planning process. HIV is marginalized and treated like any other chronic illness, which is unacceptable. The system needs to improve to reduce risk and ensure treatment. We can't arrive one week late like we did in Chaquelane.

Participants living with HIV perceived they would not receive appropriate health-care services in the TACs if they did not have their cards. Therefore, in many circumstances, they returned to their homes in the middle of the crisis to retrieve their cards and these minutes could have been fatal for them.

In all areas visited, respondents confirmed that condoms were distributed and were made available up to the day of the interview. It was unclear though if both male and female condoms were part of this distribution and of emergency relief supplies. Respondents noted that information-sharing and prevention campaigns related to condom use and protection against STIs, including HIV, were carried out, but they also explained that these campaigns were implemented sporadically and often they were unorganized. Respondents noted that local activists worked tirelessly to deliver prevention messages during the acute red alert phase of the emergencies, the early recovery phase and post recovery. It was also noted that drama performances and TV campaigns were done to deliver prevention messages, among other things.

Treatment and care were among the major gaps that emerged. PEP services were non-existent. PEP refers to services provided to prevent HIV infection in an exposed individual. PEP is part of a comprehensive service that includes first aid, exposure risk assessment, counselling and, depending on the outcome of the exposure assessment, prescription of a 28-day course of antiretroviral drugs (IASC, 2010). As well, it consists of appropriate support and follow-up and emergency contraception

and presumptive treatment for STIs. A representative from UNICEF confirmed that the catalogue for ordering various health kits for emergencies in Mozambique has only included PEP since 2017. There are no guidelines or checklists for emergency planning to incorporate how to manage rape cases or other modes of occupational exposure to blood-borne pathogens. At the time of interview, PEP was not available in the country for the purpose of emergency response.

A respondent from UNICEF confirmed that STI medications were included in the supplementary inter-agency emergency health kits. However, it was unclear if the preparedness for STIs in emergencies included a comprehensive public health package and case management readiness.

Basic first-level ART medications are not part of the current stock of medications delivered to the accommodation centres, putting continuity of HIV treatment at risk. The use of ART for the prevention of mother-to-child transmission (PMTCT) as an intervention within emergency settings remains a gap among other reproductive actions that the IASC recommends, such as safe and clean deliveries. Respondents did not identify family planning services as being offered during the acute red alert phase of emergencies except in terms of condom distribution.

Another challenge that has emerged is voluntary counselling and testing (VCT) services for children and adults alike. Respondents confirmed that, at some point, VTC services were made available, but these appeared inconsistent among communities. According to many respondents, the confidentiality and privacy of testing services were violated in various communities visited; the respondents cited the incident during the 2013 flooding as a main example.

Participants also noted that their treatments were interrupted due to lack or insufficient provision of food aid, particularly for those under ART, and at times for a period up to three months.

> “I had to stop taking my medication for three months because the medication was too strong and I did not have enough food. When I tried to go back on the medication, the nurse scolded me; I felt ashamed. I started taking the medication again and I got diarrhoea. My neighbour had to take me back to the hospital. I am better now and continue on my treatment.”
>
> *(Participant, Xinhancanine)*

Other participants noted that although their treatments were put off, they eventually got back on ARTs, but access to co-trimoxazole prophylaxis as a prevention treatment for a wide range of infections that HIV-positive people are vulnerable to was discontinued for all of them. Participants noted that they felt better while on co-trimoxazole and during the crisis they felt weak and sick. In all field visits and with all respondents interviewed, continuation of ART was a major gap and did not occur owing to issues related to access to food.

In both Zambézia and Gaza provinces, static health centres are the normal modes of routine delivery of health services. Mobile clinics are increasingly being established to support routine delivery of health services in hard-to-reach areas. However, mobile clinics do not routinely offer HIV-related services according to participants. In flood-prone areas, mobile health services are occasionally set up in evacuation centres and camps to provide basic health services such as malaria treatment and mosquito nets. The spectrum of HIV prevention and treatment services is not provided, except opportunistic infections treatment. Antiretroviral drugs are only accessed in government health centres, often unreachable during such times. In some cases, activists, HIV associations and GAACs brought HIV medications to the camps and resettlement communities when they were able.

> The *activistas* work very hard. The critical time for HIV patients is when they leave the accommodation centre and return to their homes. They have lost everything and have no food.
>
> *(Key informant, Chaquelane)*

HIV outreach and home-based care (HBC) services were generally limited, and where they existed, they were provided by activists working with community associations such as Kutxinga in Gaza. However, during periods of heightened emergency, the activists and local health-care providers were displaced themselves, interrupting continuity of the delivery of these services. Although this paper mainly focuses on two case studies, Gaza and Zambézia, with particular emphasis on flood-affected communities, we were able to gather some data related to conflict-induced emergencies in Mozambique and drought. For example, one respondent from Médecins Sans Frontières (MSF) described how insecurity due to conflict in the province Tete had also prevented access to HIV medication:

> The conflict in Tete has caused many of our patients, especially the men, to default on their treatment. They hide in the bushes outside the health centre, hoping to get service but fearing they will be targeted. As a result, many of the government-run health centres have been abandoned due to fear the health staff will also be attacked.
>
> *(Key informant, Maputo)*

In flood-prone areas, community health workers who provide HBC services were also affected, leading to halting of services, including the breakdown of psychosocial support groups. Health authorities reported difficulties in reaching populations with basic medical services and provision of ART as they migrate farther from health facilities.

Therefore, there is no evidence of scale-up of HIV prevention, care and treatment services during emergencies. HIV risk increases during emergencies as a result of transactional sex, negative coping mechanisms and increased SGBV. This calls for contingency planning for HIV response based on the context that HIV remains a public health problem in Mozambique.

During the fieldwork for this paper, gender issues emerged as a strong factor for HIV risk. Gender issues impacted on participants' perception of the need to be tested and treated. For example, one female participant from Matebe community described one issue:

> Men refuse to be tested because of their image being a man. They would like to test in private but the health centre is far and they feel they would be pointed out if they go.

3.4. Food and Nutritional Support

During emergencies like drought and flooding, relief food requirements increase among the affected populations. Relief food is made available by the government (INGC), United Nations (World Food Programme (WFP)) and NGOs. Literature and interviews indicate that a coordinated response, which recognizes the issue of HIV, is lacking; hence, coverage and targeting of vulnerable groups, especially PLHIV, is compromised. Despite the availability of relief food especially in TACs, frequency of food distribution and quantity may not meet the nutritional needs of PLHIV due to the lack of variety of food or balanced diet.

ART defaulting was noted, as patients failed to continue their care and/or treatment due to insufficient food, pipeline break and stock-outs. PLHIV on ART have been especially affected by the drought and require minimum nutrition (including clean water) to take their ARTs. The need to access health services for opportunistic infections is paramount.

> Maria was sick with HIV during the emergency. She could not tolerate her medications because of lack of food and she did not receive any support. She felt constrained to identify herself at the camp because she felt like this would be used against her, like when two people have an argument and then they point to her and say she is sick with HIV. After a few months, she died.
>
> *(Key informant, Matebe community)*

Based on the interviews conducted, respondents demonstrated limited knowledge and described weak involvement of vulnerable groups in preparedness and response planning. As well, interviewees expressed there is little advocacy for PLHIV in general, let alone in emergencies. Interviewees claimed that HIV in emergency received little attention, resulting in the needs of PLHIV not being met during emergency situations and with little or no rations allocated for PLHIV and other vulnerable groups.

Although interviewees from relief agencies felt that the basic nutritional needs of the most vulnerable persons were being addressed, FGD respondents mentioned that not all vulnerable groups, including PLHIV, most of whom are poor, were being reached with food aid. Various programmes, such as Food for Asset (FFA), were in place. However, some respondents reported that PLHIV were weakened by the drought or flooding and wanted to participate in the FFA programme, and, as a result, since the FFA programme entailed intensive labour, they discontinued their ARTs in order to participate in the FFA programme because interviewees claimed that they felt weak as a result of the ARTs, especially during emergencies where they claimed food was inadequate for their needs. Respondents expressed preference for an inclusive approach to emergency planning, such as being asked to join food committees or emergency planning committees so that they could understand their rights more fully. There was no mention of any type of emergency planning committees in any of the communities visited.

Interviewees described the major gaps that exist in establishing the actual need for food by PLHIV. It was noted by health workers that documentation on vulnerable PLHIV in need of food aid or on the proportion of those reached other than those needing supplementary feeding, which is also known as food by prescription (FBP), was not available. The areas visited were rural with high poverty index. Participants stated that relief food was generally inadequate to cater for the needs of the community and hence increased the vulnerabilities to HIV due to poor coping mechanisms. Adherence to ARTs is interrupted due to lack of proper nutrition. All respondents interviewed for this paper confirmed that this is an issue; however, it would be useful to have data to measure the magnitude of ART defaulting for lack of food.

3.5. Access to Water, Sanitation and Hygiene

PLHIV need clean and safe water to take medication and use for hygiene. There was no evidence of specific water, sanitation and hygiene (WASH) interventions targeting PLHIV needs. The Resident Coordinator of Matebe explained that clean water was an issue. Although they have three boreholes, only one has clean and safe water. Participants said that it was likely that community members consumed water directly without boiling or using treatment chemicals. This poses risk to water-borne diseases for PLHIV. Data on the distribution of water containers and filters was not collected, and it is difficult to ascertain if it occurred and whether or not it reached everyone in need and whether preference was noted for any clean water, sanitation and hygiene issues for PLHIV.

Another issue raised by the Matebe community was the clean latrines. They lacked proper chemicals and cement slabs to keep the latrines hygienic. Consequently, water contamination with human waste during flooding can result in diseases and place the already vulnerable immune systems of PLHIV in further jeopardy.

The period during and after disasters signifies a time of great risk in the transmission of infectious diseases especially for PLHIV. Conditions are often unsanitary and conducive to disease outbreak, particularly in TACs and resettlement camps where large numbers of people gather with limited and sometimes deteriorating living conditions. The associated risks to health are due to lack of safe drinking water, poor sanitation and hygiene practices. Early identification of appropriate, technically sound and sustainable WASH interventions is therefore critical for a fast and effective response to disasters. Interventions that improve water supply, sanitation and hygiene practices will greatly reduce disease transmission, alleviate the suffering of PLHIV, keeping them safe and saving their lives.

3.6. Protection

According to the IASC (2010) guidelines for addressing HIV in emergencies, protection is one of the key actions. Under these guidelines protection is implemented to ensure “that everyone (irrespective of their age, sex or social status) is able to enjoy their rights on an equal basis, in safety, with dignity, including in times of internal or external displacement” (IASC, 2010:35). It is important, therefore, that coordination and preparation are essential to protect and assist people during times of crises. Therefore, in order to protect children, PLHIV and key populations at higher risk of exposure to HIV, the IASC recommends that a human rights-based approach is central in response to HIV in humanitarian crisis settings. By embracing this approach, vulnerability to HIV and stigma and discrimination against PLHIV can be effectively reduced.

During the fieldwork for this paper, many protection issues emerged alongside gender issues (see next section). One participant described that when she went to do her donor assessment visit in Chaquelane, she saw that HIV health services delivery in the accommodation centre was in violation of protecting people's right to privacy and confidentiality. She described it as follows:

> In the tented camps where the delivery of health services operated, the health staff designated one line specifically for HIV-positive people. They would shout out – "all HIV-positive people line up here" or "the HIV line is that one". There are many reasons why people do not want to disclose their status. They might be public servants, they may not have told their spouse of their status…and, as a result, people did not choose to get HIV services during this time due to this constraint.
>
> *(Donor-funder participant)*

Therefore, if PLHIV wanted services related to HIV, they were forced to publicly disclose their status. The above participant explained that health service delivery did not protect people and placed them in a situation where discrimination would likely occur and, as a result, their human rights were violated. When one participant was asked about this lack of privacy, this was the response:

> What could I do? I had to stand there. I needed my medication, I didn't want to die. I could do nothing.
>
> *(Participant, Chaquelane)*

For all communities, HIV-related stigma and discrimination still exist. In the province of Zambézia, stigma was strong and affected people's perception of getting support. One participant explained:

> Most of us here are infected but we cannot talk about it because of shame.
>
> *(Participant, Matebe community)*

In terms of GBV, when asked about violence as a problem, participants within the communities in the province of Zambézia did not perceive it as a prevalent issue during emergencies. However, when these same participants were asked if they knew someone who experienced an incident of GBV, such as rape, sexual abuse or sexual exploitation, they could not recall anyone they knew but said it could happen, although rare. However, when participants in Gaza province were asked the same question, they had many stories of GBV and rape, especially cases involving women and young girls who were displaced from Guija and Chokwe to Chaquelane. These rape cases were also noted by the district focal point at the CNCS in Xai Xai, saying that this was a problem during the 2013 emergency and they lacked protection services. Participants explained that rape and sexual abuse cases were rarely reported and therefore proper statistics were unavailable.

3.7. Capacity

During the field visits for this paper, it was reported that there were few partners supporting HIV and AIDS activities during drought and flooding. There was a mention of disaster committees, which might offer the opportunity to represent vulnerable populations, including PLHIV, in the community. Participants reported that APEs, HIV/AIDS/health associations such as Kutxinga, and other voluntary activists were a key support for PLHIV and should be provided with additional training and support to continue their work. Involvement of PLHIV or the vulnerable population should cut across all the committees that are formed to address disaster, floods, droughts and relief that is associated with emergencies. Access to health-care services is already limited in Mozambique, even more so for rural communities. In flood emergencies, where critical infrastructure, including health services, are severely disrupted, it becomes increasingly difficult to timely address emerging health concerns, including chronic diseases such as HIV/AIDS.

3.8. Coping Mechanism during Extreme Food Scarcity

Despite the fact the GAM rates were poor (9.1%) as indicated in the SETSAN 2016 food security and nutritional assessment, no deaths were reported as a result of the food insecurity and nutrition situation (Minister of Health and SETSAN, 2016). This can highlight the resilience of the communities, partly because of the recurrent shocks they are exposed to, and also the existing coping mechanism (see Table 3). Further, evidence based on different assessments during this time (2016) gave contradictory results, and, therefore, further assessments were recommended to corroborate results to inform emergency response (Minister of Health and SETSAN, 2016). Consequently, it was requested that during fieldwork for this paper, questions about coping mechanisms of people during periods of food scarcity and insecurity to further produce evidence surrounding this issue be added. Table 3 provides a snapshot of the responses related to coping mechanism questions and food insecurity and scarcity. It is important to point out that no in-depth analysis was done on this and it would be important for further investigation into existing coping mechanisms to determine if there are other types of coping mechanisms used and to what extent theses coping mechanisms contributed to resiliency.

Table 3: Coping Mechanisms during Periods of Food Scarcity and Insecurity

Gaza	Zambézia
1. People sell charcoal to earn money to buy food.	1. Selling charcoal is a way for people to earn money to buy food.
2. People sell livestock (e.g. chickens, ducks) to earn money to buy food. Respondents mentioned that during extreme food insecurity, livestock would sell at a very low price because animals were skinny and often sick (in rare cases, cows).	2. People also sell reeds which are used to make baskets. These baskets are put up for sale to generate income to buy food.

Gaza	Zambézia
3. People sell what is known as "*sura*" or "*odjema*" (depending on the location) – a fermented drink made from palm trees that are used to produce alcoholic beverages. (Parents also give the non-fermented form of this drink to their children to feed them, as it produces a very sweet non-alcoholic taste prior to fermentation.)	3. Catching fish in the river, when possible, has been another strategy to supplement the people's diet.
4. The wild food xicutsi is used to make sweet tea. Drinking tea has been a coping mechanism of the people.	4. Cassava is used when they can find it. They grind it into starch, add water and any green leaves, such as the cassava leaves, to make soup. Anything else may be added. They usually eat only one meal a day.
5. Family members who live in Maputo or who have migrated to South Africa to work in the mines, for example, send food and/or remittances to assist their families left behind in the province during times of food scarcity.	5. Respondents also noted that they consumed boiled cassava alone during food scarcity.
6. Transactional sex has been reported as a way to earn money. As well, marrying off daughters to gain *lobolo*[2] is also a coping mechanism. Child marriages would fall into this category.	6. Transactional sex was noted as a possibility, but respondents said that this would be rare.
7. Cassava is also consumed in periods of food scarcity.	7. Fruit, such as banana, was noted as a possible food item consumed if they found it.

[2] *Lobolo* is a symbolic sociocultural practice of paying a bride price, largely practised among Southern African peoples (Oxford University Press, 2018). See https://en.oxforddictionaries

4. DISCUSSION

This section consists of key points and a list of recommendations that can assist in taking action to better position the government and humanitarian actors, including IOM, to respond – in a systematic and structured manner – to the encountered HIV-related needs in emergencies. The findings presented were sorted and analysed in accordance with the IASC guidelines for addressing HIV in humanitarian settings, which allows the government and humanitarian actors to easily begin to integrate issues surrounding HIV in emergencies into the current policy.

4.1. Key Points

- HIV is not considered a part of emergency planning. Local governments are not aware of HIV as a component of emergency and response planning.
- Limited access to health-care services and HIV stigma are significant obstacles to HIV prevention, care and treatment particularly during flooding and more notably during times of drought. Locations of health facilities are generally far and funds are seldom available for people to reach these facilities.
- Gaps in protection are evident. These vulnerabilities relate mostly to cases of transactional sex and school dropouts, and we know early marriages exist in Mozambique, with 50 per cent of girls being married before they are 15 (UNICEF, 2015). Cultural norms and beliefs interfere with the management of SGBV and rape cases, and thus result in non-reporting.
- No PEP was noted, resulting in a major gap in prevention of transmission.
- Migration (rural–urban and rural–rural) is a considerable factor increasing vulnerability to HIV transmission as well as disruption in the continuation of HIV care and treatment services.
- Inclusion of PLHIV as a vulnerable group in humanitarian relief efforts is not done consistently and is dependent on the service provider.
- Humanitarian actors have limited knowledge of the IASC guidelines for addressing HIV in humanitarian settings, and there is little evidence of the incorporation of these guidelines into emergency planning and response planning.
- National contingency planning for flooding should place more emphasis on the continuation of HIV services in TACs and resettlement camps, and ensure the inclusion of PEP services.

4.2. Recommendations

Government

- Government to prioritize the inclusion of HIV/AIDS in its emergency and disaster management structure as a permanent pillar for emergency, and identify concrete and practical interventions to be included in the 2017–2018 national contingency plan.
- The INGC and the MoH to promote systemic integration and adoption of the IASC guidelines for addressing HIV in humanitarian settings. This starts with the inclusion of HIV as a critical pillar and function of emergency preparedness and response planning in the national contingency planning.
- The HCT or the RCO to provide overall leadership, coordination and support for an integrated multicluster approach to addressing HIV in emergencies through the adoption of key actions from the IASC action framework.

Clusters

- The Health Cluster should strongly promote and advocate, under the leadership of WHO, the systemic adoption and application of the IASC guidelines for addressing HIV interventions in emergencies. This will require integration of the IASC guidelines into the humanitarian programming and capacity development of local communities and organizations on the use of the guidelines.
- The Nutrition and Food Security Clusters, under the leadership of UNICEF and WFP, should give adequate attention to HIV in emergency settings. This includes ensuring access to adequate food and nutrition for PLHIV in TACs and resettlement camps and an assessment of the nutrition status of PLHIV to ensure the delivery and customization of appropriate interventions.
- The Protection Cluster to ensure the mainstreaming of protection and GBV throughout the emergency programming life cycle. Use early warning systems and GBV early warning indicators to improve emergency response and planning for HIV in emergencies. This may include setting up a surveillance system that can capture the impact of drought or flooding on access to care and treatment services, including adherence to ARTs and incidents of GBV.
- The Protection Cluster to strengthen protection services within CCCM to prevent human rights violations against PLHIV during humanitarian interventions, particularly, but not limited to, stigma and discrimination.

Agencies

- UNICEF to continue to support and further strengthen community capacity in providing HIV/AIDS-related services prevention and treatment by building on the work of APEs and scaling up mobile brigades to include HIV in emergency planning and response.
- UNFPA to lead government support to ensure the readily provision of PEP kits in order to address occupational and non-occupational exposure, particularly in CCCM.
- IOM to continue to build the decentralized capacity of the government, partners and communities in CCCM.
- IOM, together with UNICEF, to lead training for the INGC, before the upcoming emergency season in Mozambique, on the issue of HIV during humanitarian interventions, guided by the IASC guidelines.
- WFP to lead the endeavour in addressing the issue of food security for PLHIV during emergencies, paying particular attention to the constraints on adhering to ART without adequate food. UNICEF to co-lead this effort.

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