

The Health Sector Gap in the Southern Africa Crisis in 2002/2003

Andre Griekspoor
World Health Organization

Paul Spiegel
United Nations High
Commissioner for
Refugees

William Aldis
WHO Representative,
Malawi

Paul Harvey
Overseas Development
Institute

The southern Africa crisis represents the first widespread emergency in a region with a mature HIV/AIDS epidemic. It provides a steep learning curve for the international humanitarian system in understanding and responding to the complex interactions between the epidemic and the causes and the effects of this crisis. It also provoked much debate about the severity and causes of this emergency, and the appropriateness of the response by the humanitarian community.

The authors argue that the over-emphasis on food aid delivery occurred at the expense of other public health interventions, particularly preventative and curative health services. Health service needs were not sufficiently addressed despite the early recognition that ill-health related to HIV/AIDS was a major vulnerability factor. This neglect occurred because analytical frameworks were too narrowly focused on food security, and large-scale support to health service delivery was seen as a long-term developmental issue that could not easily be dealt with by short-term humanitarian action. Furthermore, there were insufficient countrywide data on acute malnutrition, mortality rates and performance of the public health system to make better-balanced evidence-based decisions.

In this crisis, humanitarian organisations providing health services could not assume their traditional roles of short-term assistance in a limited geographical area until the governing authorities resume their responsibilities. However, relegating health service delivery as a long-term developmental issue is not acceptable. Improved multisectoral analytical frameworks that include a multidisciplinary team are needed to ensure all aspects of public health are dealt with in similar future emergencies. Humanitarian organisations must advocate for improved delivery and access to health services in this region. They can target limited geographical areas with high mortality and acute malnutrition rates to deliver their services. Finally, to address the underlying problem of the health sector gap, a long-term strategy to ensure improved and sustainable health sector performance can only be accomplished with truly adequate resources. This will require renewed efforts on part of governments, donors and the international community.

Public health interventions, complementing those addressing food insecurity, were and are still needed to reduce the impact of the crisis, and to allow people to re-

establish their livelihoods. These will increase the population's resilience to prevent or mitigate future disasters.

Keywords: development, food crisis, food insecurity, health services, HIV/AIDS, humanitarian response, vulnerability.

Introduction

The humanitarian response in southern Africa during 2002/3 provoked much debate within the humanitarian system about the severity and causes of the situation as well as the appropriateness of the response. This article uses the term southern Africa 'crisis' (throughout this article the authors will continue to use the word 'crisis' (without the quotations) to describe the situation for consistency) to refer to the six southern African countries that were included in the UN's consolidated appeal process (CAP); Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. The authors acknowledge that there is an ongoing debate about the severity of the crisis, and indeed whether it was a crisis at all, and that the choice of the six countries was a construct of the international community (Darcy et al., 2003; Fedida, 2003).

A critical analysis of the health sector response to the situation in southern Africa will be the focus of this article. The relative neglect of health versus other sectors and the factors behind this neglect will be discussed. The authors argue that an over-emphasis on food-security assessments and related analytical frameworks contributed to a narrow priority setting process. While ill-health related to HIV/AIDS was identified as major causal factor of the crisis, there was a limited humanitarian response to address wider health issues. Interventions to prevent disease and access to adequate curative services to reduce illness and malnutrition-related morbidity and mortality are essential humanitarian response priorities besides the supply of food.

The authors argue that there was a 'health sector gap' in the response to the crisis and present a model to aid in its conceptualisation. They then analyse the factors behind this gap in terms of the way the crisis was conceptualised and assessed, the divisions between humanitarian and development assistance and the role of HIV/AIDS. It argues that the health sector gap in the southern Africa response occurred because health was seen as a long-term developmental issue that could not be easily addressed by short-term humanitarian action. However, in much of southern Africa, development actors have failed in their efforts to help the governments to provide acceptable levels of basic health services. Furthermore, access to health services has been declining over a number of years. Questions of and some solutions for the responsibility of humanitarian actors in situations where morbidity and mortality levels do not necessarily reach crisis levels and where access to health is already below minimum standards are proposed.

The southern Africa crisis

In March 2002, assessments estimated that 12.8 million people were threatened by starvation and communicable diseases in southern Africa and in need of assistance; this figure was later increased to 14.4 million (UNOCHA, 2002a). Regional CAPs were launched and substantial amounts of assistance were provided to the six countries

included in the appeals. In fact, HIV prevalence in the six southern African countries targeted for crisis were as follows: Mozambique with 10–14 per cent; Malawi with 15–19 per cent; Zambia with 20–24 per cent; Lesotho, Swaziland and Zimbabwe all with 35–39 per cent.

The southern Africa crisis was characterised in a variety of ways from acute food crisis, drought, HIV/AIDS crisis, governance crisis to a development crisis; each of these characterisations arguably describes a different facet of a complex problem (Darcy and Hofmann, 2003). There was debate about whether to include Angola in the southern Africa crisis. The country was part of the Disasters Emergency Committee (DEC) appeal on behalf of UK agencies (Valid International, 2003). The grouping of the six countries was logical for fundraising, logistical and coordination purposes, but it sometimes obscured the distinct and differing needs of the national crises in each country. The crisis may be better conceptualised as a number of distinct situations that have some common symptomatic and causal features (Darcy and Hofmann, 2003). Furthermore, the credibility of the humanitarian response in the region has been questioned due to the disparity of response between Angola, where mortality and malnutrition rates were higher in 2002 compared to the rest of southern Africa (Fedida, 2003). The recent DEC evaluation of the southern Africa response found that ‘the overall presentation of the crisis overstated the acute case’ which risks the credibility of aid agencies in future crises (Valid International, 2003).

The overall response to the crisis was dominated by food aid. Of the US\$611 million requested in the 2002 CAP, \$507 million (83 per cent) was for food commodities. The World Food Programme (WFP) was one of the few agencies to secure over three-quarters of its appeal. Although the UN system and NGOs did attempt to scale up non-food responses, these were less well funded by donors and slower to begin. By the end of June 2003, approximately 82 per cent of the \$656 million requested in the *revised* 2002 CAP appeal had been funded (RIACSO, 2003). However, there was a major shortfall in the response to the social-service sectors, where only 31 per cent of the amount appealed for was met. Funding requests for the health sector and water/sanitation were under 8 and 1 per cent of the total requested funds, respectively.

There have been concerns over the appropriateness of the response within the six countries. The UN stated that the response to the crisis was appropriate as it successfully averted the threat of famine; ‘Because of the quick response from the international community, the UN and nongovernmental organisations (NGOs) saved millions of lives threatened by starvation in Southern Africa over the past year’ (OCHA, 2003). However, others claim that the 2002 CAP reflected food aid needs to the detriment of needs in other sectors (Darcy and Hofmann, 2003). This paper will not enter into the minefield of making judgements around these debates except insofar as they relate to the health sector response.

Evidence from mortality data and nutrition surveys assessing the extent and severity of the crisis produced mixed results. In Malawi, two nutrition surveys among children under five years of age in Mchinji and Salima districts in March 2002 found high levels of global acute malnutrition of 17.5 and 19 per cent, respectively; crude mortality rates (CMRs) were 0.21 and 1.23 per 10,000, respectively (Taifour, 2002). Nutrition surveys in the Mulanje and Tyolo districts, Malawi in the same month, indicated ‘acceptable’ rates of global acute malnutrition of 6.2 and 7.2 per cent, respectively, but CMRs were above the emergency threshold of one per 10,000 per day (Steering Committee for Humanitarian Response, 2003) being 1.29 and 1.14, respectively (Chanje, 2002). The discordance between some of the acute malnutrition

rates and CMRs in the same districts either means that there are other causes for mortality beside malnutrition, or that the quality of some of these surveys can be questioned. In April 2002, a mortality survey in 40 villages pre-selected as the most food insecure in Malawi showed an alarming CMR of 1.9/10,000/day (MOHP and WHO, 2002). A follow-up survey in September 2002 showed similarly elevated rates (*ibid.*). The geographical areas surveyed were either limited to some districts or to the worst-affected villages, and thus can not be extrapolated beyond these boundaries. After the harvest and the start of a substantial food aid programme in Malawi in September 2002, nutrition and mortality surveys in 20 of a total of 28 districts plus two major urban areas reported global acute malnutrition rates between 0.8 and 6.6 per cent (Unicef, 2002). These rates are similar to those reported for Malawi in 2000 (DHS, 2000) and common in sub-Saharan Africa. The majority of the CMRs among the populations surveyed were within expected ranges. Only two out of the 20 districts reported a CMR above one per 10,000 per day (Tyolo reported 1.10 and Zomba 1.5/10,000/day).

In Zimbabwe, nutrition surveys covering 30 districts in May 2002 estimated median global acute malnutrition at 6.4 per cent, with a range of 2.8 to 10 per cent (UNOCHA, 2002b). Although there were indications that acute malnutrition had deteriorated in some districts, the result were similar to the 6.0 per cent found in Zimbabwe in 1999 (UNOCHA, 2002b). There were no recent mortality surveys done in Zimbabwe.

Overall, due to a mixture of either a lack of data, limited geographical coverage, biases and/or quality issues in the mortality and malnutrition surveys in Malawi and Zimbabwe during this period, estimates of the extent and severity of malnutrition and mortality are difficult, if not impossible, to make.

Specific needs assessments of the health sector were conducted, notably in Malawi in April 2002 (MOHP and WHO, 2002) and Zimbabwe in May 2002 (*ibid.*). These health assessments used different methodologies and did not occur in all six countries in a similarly coordinated way as was done in the food sector using the Vulnerability Assessment Committee's assessments (VACs) of the Southern African Development Community. The assessments in Zimbabwe and Malawi concluded that health-surveillance systems were poorly functioning in both countries, making it difficult to draw conclusions on the burden of disease trends. Health facility-based figures actually showed a decline in attendance whereas case fatality rates increased. Overall shortages of staff and drugs were identified. This in combination with the low life expectancies and high HIV/AIDS prevalence could indicate a declining access to services and/or a decline in its quality. There was a significant outbreak of cholera in Malawi, with 33,000 cases, as compared to 4,000 the year before (MOHP and WHO, 2002). This indicated that quality of and access to water and sanitation was inadequate to prevent such outbreaks. Again, as with the nutrition and mortality surveys, the overall picture of the health sector was unclear due to insufficient data.

Food-security assessments suggested that there was a serious risk of famine unless large volumes of humanitarian assistance, particularly food aid, could be provided. Since famine does not appear to have occurred, the humanitarian response may be considered successful and a famine possibly averted. Of course, attributing the impact of humanitarian assistance is always problematic and the claims being made about the impact of food aid must be treated with caution. It is as difficult to prove how many deaths were prevented due to a timely humanitarian response as it is to estimate how many lives would have been lost if nothing had been done. For the health sector, however, the lack of clear evidence of increased levels of morbidity and

mortality relating to the crisis made it difficult to make the case for a large and concerted humanitarian health response. Given the lack of evidence for crisis levels of malnutrition, morbidity and mortality, what responsibility did humanitarian agencies have within the health sector? The next section examines the factors behind the limited health service response to the southern Africa crisis.

Relief and development

While the framework of a simple linear transition from relief to development has been recognised to be inadequate for many years (Maxwell, 1999), a conventional humanitarian assistance model assumes that existing pre-crisis health service needs are being met within a developmental paradigm. A crisis temporarily increases health service needs often within a specific target population (for example, refugees) or over a limited geographical distribution (for example, an area affected by drought or conflict). The emergency also exceeds the capacity of the existing health sector systems to meet these excess needs and so provides a legitimate role for humanitarian agencies either in supplementing the capacity of the government or substituting for it when it is not functioning.

During the southern Africa crisis, however, the limited health assessments identified problems, but most of these had existed before in the previous years. The low access to health services at nation-wide scale was seen as a development problem rather than a humanitarian one, being complex and requiring long-term commitment, funding and resources by governments and donors. Countries had functioning governments and Ministries of Health (MOH), and there were no violent conflicts or large-scale population movements. The problems were diffuse; there were no immediately obvious specific target populations or limited geographical areas where need was much higher than other areas. Responsibility for delivering health services clearly remained with the state.

It was therefore not appropriate to set up parallel health services or to 'take-over' management of health districts, as often done by NGOs when national health authorities in conflicts are unable to fulfil their responsibilities. However, while remaining responsible, the capacity of these governments was already inadequate to address the 'normal' needs for social services. Humanitarian agencies working in health also usually do not have the capacity to scale-up services to a national level, contrary to the food aid sector. In addition, large-scale support to national health structures was sometimes seen as problematic in southern Africa, due to the perceived contribution of bad governance to the crisis. Particularly, in Zimbabwe, donor funding was restricted primarily to humanitarian response and HIV/AIDS programmes; anything that was seen as developmental or proposed working with the existing government was unlikely to be funded. For food aid at national scale, it is more readily accepted that governments are unable to provide this and that a humanitarian response is required mediated through UN agencies and NGOs. The leadership that exists in mounting a large-scale international food aid response does not yet exist in the health sector.

In crises with functioning states, it would be expected that the existence of national disaster prevention and response policies, and the existence of multi-sectoral disaster response mechanisms would also influence the configuration and appropriateness of the response. It does not seem that these policies played an explicit

operational role in the humanitarian response to the southern Africa crisis. Often disaster policies are dominated by a particular type of preparedness, like famine early warning based on the food-security model that fails to take into account health. Updating such policies so they take into account the slow decline of social services and the HIV/AIDS epidemic would be timely.

The health sector gap

Prior to the 2002/3 crisis in southern Africa, health service delivery systems were already under considerable strain. There is considerable variation across the six countries in the region. Swaziland, and to a lesser extent Lesotho, have relatively well-funded health-care systems. Zimbabwe once had an impressive primary health-care system but it is currently under massive economic and political strain. Zambia, Mozambique and Malawi have poorly functioning and under-funded systems. In Malawi, access to basic health services is very limited, with only 49 per cent of the population having access to essential drugs (UNDP, 2002) (see Table 1).

In analysing why health services remained relatively neglected in the southern Africa response, it is helpful to conceptualise the changing health service needs of the population over time (see Figure 1). The shaded area in Figure 1 presents the decline in basic health services graphically. Reduction in such services over time is due to a complex series of factors including poverty, attrition of health workers, underinvestment, poor governance and the inability of people to access services.

Simultaneously, while access to basic health services has been declining, the need for such services has been increasing, notably due to HIV/AIDS. This is represented in Line I, which shows increasing levels of morbidity and consequent stress on existing health systems. Arrow A indicates the needs existing prior to the 2002/3 crisis that were already not being met by government health services. This represents the needs generally addressed through long-term development assistance. However, the fact that access to health was declining prior to the crisis rather than rising to meet the increasing needs, demonstrates that over recent decades development assistance failed to address this gap.

The 'excess' needs attributed to the crisis are shown by arrow B. The crisis in southern Africa in 2002/3 temporarily increased health service needs. People suffering from acute malnutrition, particularly when also living with HIV/AIDS, have reduced immunity and are more likely to fall sick, for example from acute respiratory tract infections and diarrhoeal diseases. At times of severe food shortages, when people are more concerned with finding food to eat, food hygiene may be ignored resulting in diarrhoea. Families can often no longer afford paying for water from improved sources, and fall back on water from rivers or other unprotected sources that are often contaminated, again resulting in diarrhoea but also increasing risks of epidemics such as cholera (UNOCHA, 2002c). Line II represents the temporary additional increased health service needs due to morbidity arising from food insecurity. Studies of excess deaths in drought crises in Asia and Africa consistently showed that infectious diseases have been a major determinant of famine mortality (de Waal, 1989; Dyson, 1991). However, as stated in the previous section, evidence to show that current or predicted increased health needs relating to the southern Africa crisis were addressed is limited.

The full health service gap is represented by arrow C. The problem in southern Africa during 2002 and 2003 was that health needs relating to the crisis were

Table 1 Food security, health and HIV/AIDS indicators for southern Africa, 2001 (in 000s)

	<i>Lesotho</i>	<i>Malawi</i>	<i>Mozambique</i>	<i>Swaziland</i>	<i>Zambia</i>	<i>Zimbabwe</i>
Population 2001 (total)*	2,057	11,571	18,644	937	10,648	12,851
Vulnerable population targeted for food aid (total; %) [§]	445	3,188	515	231	2,329	6,075
Estimated prevalence of adults (15–49 yrs) living with HIV/AIDS, end 2001 (%) [¶]	31.0	15.0	13.0	33.4	21.5	33.7
AIDS mortality 2001 (total) [¶]	25	80	60	12	120	200
Life expectancy at birth 2001 (yrs)*	40.0	36.3	44.8	40.2	36.8	36.8
Population with access to essential drugs (%) [¥]	80–94	0–49	50–79	95–100	50–79	50–79
Per capita gov't health expenditures US\$)*	23	5	6	40	11	18

* WHO, 2002. [§] UNOCHA, 2002a. [¶] UNAIDS, 2002. [¥] UNDP, 2002.

difficult, if not impossible to distinguish from existing gaps in health services. Figure 1 highlights the difficulty in addressing excess morbidity relating to a crisis without addressing the existing and increasing deficit in coverage and access to health services. Addressing the full health service gap represented by arrow C would, therefore, require a concerted action to tackle both the short-term health needs arising from an emergency as well as the long-term decline in health services.

The categorisation of health as a long-term development problem partially explains the health sector gap in the southern Africa crisis. The way the crisis was conceptualised is another factor that caused the relative neglect of the health sector. Although HIV/AIDS was identified early in the crisis as an important factor, the situation was labelled as a food crisis, mainly based on the calculated food shortages from WFP and Food and Agricultural Organization's crop and food-security

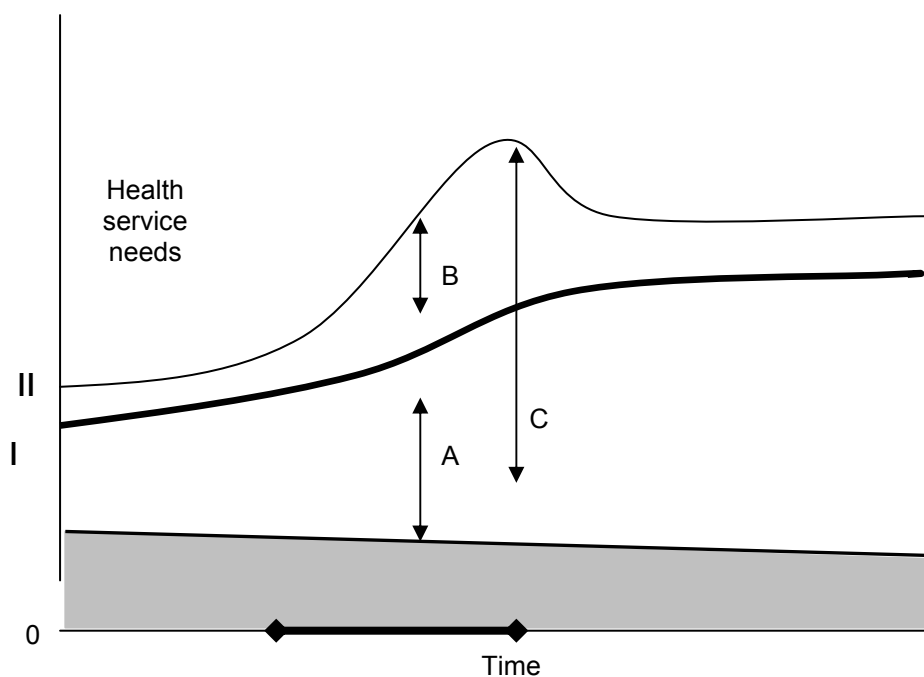


Figure 1 Changing health service needs of a population over time during the southern African crisis. Shaded area represents baseline level of health services provided (slowly decreasing due to attrition of health workers, under-investment, and inability of people to access services because of poverty and chronic illness)

◆ — ◆ = period of erratic rainfall

I = Baseline health service needs (increasing due to HIV pandemic, poverty and other reasons)

II = Increased health service needs during crisis (including effects of food insecurity)

A = Existing gap in access to basic services

B = Unaddressed 'excess' health service needs caused by food insecurity

C = A + B = Total health service deficit

Source: Figure adapted from Griekspoor and Colombo, 2002.

assessments. The response by the humanitarian community to the southern Africa crisis was based on a gradual accumulation of evidence from a range of informal and formal sources, including crop assessments that predicted significant food shortages, across the six countries (Darcy et al., 2003). To determine levels of food insecurity, make estimates for food aid requirements and set criteria for targeting regions and subpopulations, VAC assessments were conducted across the six countries; these assessments are based on the food-economy approach (Boudreau, 1998). They primarily focused on determining food shortages and hardly examined health either as a need or a vulnerability factor. For example, the Zimbabwean VAC questionnaire asked if families had to reduce expenditures, including health services, but did not enquire if there was an increase in frequency of illness or if the families' access to health services had changed. It also did not sufficiently examine the extent to which

ill-health or premature deaths in households affected coping mechanisms or changed dependency ratios (Zimbabwe VAC, 2002). In part, based on these assessments, food aid became the dominant response to the crisis, and agencies soon became fully stretched in scaling-up initially limited relief capacities to organise a massive food aid operation.

The livelihoods framework could potentially provide a much broader understanding of these complex situations as human health is part of the asset portfolio upon which livelihoods are based (Jaspers and Shoham, 2002). However, its full implications are seldom considered. Health as a resource, the disease burden or access to health services and environmental health including access to improved water sources and sanitation are rarely adequately addressed within livelihoods assessments. Particularly in the context of the HIV/AIDS epidemic, it would be timely to broaden the field of practice to match the theoretical ideas represented in the livelihood framework.

But the livelihood approach also has specific purposes and biases. The need for sectoral analytical frameworks will remain as they provide more in-depth understanding as also required for specific interventions. What is needed, however, is a broad-based multisectoral analytical framework for a more objective and balanced understanding of all factors, causes and interactions related to survival, livelihoods and the protection of human rights. The assessment framework recently developed for the Consolidated Appeal Process 2004 is a significant step in this direction (UNOCHA, 2004). However, more work is required on this tool and the process to apply it, to ensure that the needs, risks and vulnerabilities of the affected populations can be analysed to understand causes, effect and interactions. This would then be the basis to formulate better balanced priorities between sectors and to design the most appropriate approaches for implementation strategies. A multidisciplinary team consisting of different organisations, including national stakeholders as appropriate, with a wide range of expertise would be needed to ensure that all sectors are adequately covered and given equal prominence (de Waal, 2000). This policy dialogue is needed to ensure that humanitarian interventions are also developmentally sound and that respective roles and responsibilities are clearly defined.

The challenge of HIV/AIDS in emergency situations

The southern Africa crisis represents the first widespread emergency in a region with a mature HIV/AIDS epidemic. It provides a steep learning curve for the international aid system in understanding and responding to the complex interactions the epidemic has had with both the causes and the effects of this crisis (Harvey, 2003). Identification of HIV/AIDS as one of the key underlying factors leading to food insecurity in southern Africa took place relatively early on in the international response in 2002 (RIACSO, 2003). A mission to the region by the UN Special Envoy for Southern Africa in September 2002 (Morris, 2002), and another one that also included the UN Special Envoy for HIV/AIDS in Africa in January 2003 (Morris and Lewis, 2003), placed HIV/AIDS firmly at the top of the agenda and called for a change in the traditional pattern of response in both humanitarian emergencies and development contexts due to the magnitude and the effects of the epidemic.

There have been a growing number of analyses of the bi-directional links between HIV/AIDS and food security (de Waal and Whiteside, 2003; Harvey, 2003;

Loevisohn and Gillespie, 2003). They focus primarily on the negative impacts of HIV/AIDS on people's livelihoods due to increasing levels of illness and death leading to reduced availability of labour, reduced incomes and overstretched social capital; these lead to increased levels of poverty and livelihood vulnerability, and reduced coping mechanisms. Furthermore, people living with HIV/AIDS (PLWH/As) have increased nutritional needs, and when malnourished, will be even more susceptible to diseases, further increasing their risk of premature death. PLWH/As are ill more often, and thus their need for and costs of health-care increase. While the pressure on the health system increases, its capacity to respond is eroded due to increasing staffing shortages as health workers themselves are equally affected. HIV/AIDS is estimated to be the cause of between 19 and 53 per cent of all deaths of government health employees in African countries.(Tawfik and Kinoti, 2001). Conversely and equally important, worsening levels of livelihood insecurity increase the risk of HIV/AIDS transmission. People may be forced into risky strategies such as transactional sex. Voluntary migration to obtain disposable income, often to higher prevalence urban areas, splits families and may also lead to risky behaviour.

Despite significant advances in knowledge of how the HIV/AIDS epidemic has affected populations over the past decade, there are significant gaps in theory and data. Many recent concepts, such as the 'new variant famine' (de Waal and Whiteside, 2003) are theories that are not yet supported by data. Most studies on HIV/AIDS and food security have occurred in rural areas in stable countries (Baylies, 2002); neither the impact of HIV/AIDS on urban and peri-urban food security and livelihood systems nor in unstable countries (for example, conflict, natural disasters) are known (Harvey, 2003). No studies have been published on the link between an individual's HIV/AIDS status and his/her food security situation and that of their community. Instead, quantitative economic household studies have been undertaken that are then often linked to an estimate of HIV prevalence in that community, if known. In some instances, proxy indicators for AIDS in the household, such as dependency ratio, number of chronically ill adults, and number of fostered orphans have been used. The sensitivity and specificity of these proxy indicators are unknown. Furthermore, the extrapolation of data and conclusions at the household level to the community and country level is unwarranted. More systematic, representative and prospective studies are needed to ensure our future policies and programmes are evidence-based.

Clearly, HIV/AIDS is a long-term challenge that will continue for decades. The consequent reduced resilience and increased vulnerability of populations due to HIV/AIDS may lower the thresholds for future emergencies to occur, resulting in more severe, more frequent and longer crises. This raises particular challenges for the humanitarian system that is largely premised and funded on the expectation that interventions will be short-term. Again, this raises the key issue of the distinctions between relief and development. Revised guidelines for HIV/AIDS interventions in emergency settings have recently been completed that incorporate a multisectoral and hierarchal approach to implementing such programmes (IASC, 2002).

HIV/AIDS is not simply a health condition. It must be mainstreamed across all humanitarian responses and development strategies. However, HIV/AIDS remains a disease to which a health component is an essential component of any overall response. Increased resilience, defined as 'the active responses that enable people to avoid the worst impacts of AIDS at different levels or to recover faster to a level accepted as normal' should be an important objective (Loevisohn and Gillespie, 2003: 17). Adequate preventive and curative health services can delay the onset of illness in people, increase their chances of recovery and postpone their death. However, a proper

health sector response to HIV/AIDS will have to occur over decades. This brings us back to the question of how should humanitarian actors address the health sector in situations like southern Africa, where health services and access were already inadequate and the HIV/AIDS epidemic presents a further massive long-term health challenge.

Humanitarian health sector response options for the southern Africa crisis

There are a number of reasons why HIV/AIDS must concern humanitarian actors working in the context of the epidemic:

- The mortality and suffering created by HIV/AIDS is a humanitarian concern in its own right. The impact of the epidemic is growing and will be felt for decades.
- HIV/AIDS has negative effects on household food security, adding another burden to already vulnerable households. This will make communities more vulnerable to other shocks, such as drought or conflict.
- HIV/AIDS has particular characteristics that may create new types of vulnerabilities and exacerbate existing ones. This will need to be recognised in responding to crisis.
- Emergency situations may increase people's susceptibility to the transmission of HIV/AIDS, further fuelling the epidemic.

A recent report argues that there is a need for clarity in distinguishing between the different challenges that the HIV/AIDS epidemic creates for both relief and development assistance (Harvey, 2003). Humanitarian aid is only part of a much larger international response to the impact of the HIV/AIDS epidemic, and it is important to be clear about what the relief system can and cannot do. The overall response to HIV/AIDS will occur over decades and requires a re-thinking of relief modalities, development modalities and of the links between the two. The responses of both development and humanitarian actors will need to draw upon the expertise and experiences of each other. A response across an entire country or region over many years is obviously ill suited to the ways in which humanitarian aid is currently delivered. The system is based on short-term time horizons and funding cycles. The essence of humanitarian relief should remain focused on saving lives and alleviating suffering in response to acute crises. In doing this in the context of an HIV/AIDS epidemic, it is important to apply an 'HIV/AIDS lens' to humanitarian interventions across the different sectors of response and across the programme cycle.

The analysis above has suggested that there was a health sector gap in the response to the southern Africa crisis, and that this can largely be explained by the categorisation of health issues as a developmental problem that could not be addressed by humanitarian agencies. While for food aid it was considered appropriate for UN and international NGOs to support a system for several years that could not cope, this did not seem to apply for the health sector.

Given the lack of evidence for acute emergency levels of acute malnutrition and mortality, what responsibility did humanitarian agencies have within the health sector during the southern Africa crisis? This is difficult to answer in a situation where

the development process is failing and existing levels of access to health services, clean water and sanitation are woefully inadequate.

Clearly, primary responsibility for health services in this situation remains with the governments. Establishing parallel health services would not only have been an inappropriate response to the southern Africa crisis, it would also have been impossible given the number of countries involved. For the humanitarian NGO Médecins Sans Frontières (MSF), there was insufficient evidence of emergency levels of malnutrition and mortality to justify an emergency health response; their attention remained focused on Angola, where humanitarian needs were clearly much greater (Fedida, 2003).

However, it could be argued that the humanitarian system has a responsibility to advocate for unmet health needs, whether these relate to long-term developmental problems or short-term crises. In the context of chronic conflicts and complex emergencies, a process of 'normalisation', characterised by a creeping acceptance of higher levels of vulnerability, acute malnutrition, morbidity and mortality, has been described (Bradbury, 1998). This has also recently been observed in Sudan and Somalia, where high levels of acute malnutrition not always trigger an emergency response (Bradbury et al., 2003). A situation like Malawi in 2003, where over 50 per cent of the population does not have access to essential drugs could be seen as another example of a situation in which levels that are unacceptable by humanitarian standards have become 'normalised'. Unfortunately, the unacceptable is often accepted, mostly because the actors on the ground, whether they are humanitarian or development, are simply unable to cope with the overwhelming needs. Even if no impact could have been made at national levels, advocacy to draw attention to the fact that this 'normalisation' is unacceptable and the need for a progressive realisation of the right to basic health services could be part of the humanitarian response.

Another option could be for UN and humanitarian aid agencies to refuse to accept the status quo and aim for supporting expanded access to basic health services, even if only on a short-term basis and in a limited geographical area, provided they do so within existing national health policies. Besides saving some lives, it might provide a catalyst for improved services and access in the long term. There were some limited examples of attempts to include health aspects within the overall response. For example, in Zimbabwe, the World Health Organization (WHO) managed to secure funding for the provision of essential drugs to some health centres. WHO in Malawi conducted a cholera programme that succeeded in reducing the number of cholera cases, deaths and case fatality rates in 2003 compared to the previous year and used humanitarian funding to develop a simple and robust health surveillance system with the MOH. These results show that technically correct and well-targeted health interventions can make a difference. MSF is implementing programmes in southern Africa focused on the long-term response to HIV/AIDS. For example, in Zimbabwe, MSF-Spain ran a pilot project to support the MOH in Bulawayo to provide anti-retroviral treatment (ART), and in Malawi, MSF worked with the MOH to develop national protocols for ART. This is part of a global advocacy campaign to make ART affordable in developing countries and to show that they can be successfully provided to populations in resource-poor settings (MSF and WHO, 2003). The global urgency to scale up access to HIV treatment is recognised (Stabinsky et al, 2003; WHO, 2002).

Distributing food cannot be the only answer to the combination of food insecurity, HIV/AIDS, poverty, erratic rainfall, collapsing health systems and poor governance in southern Africa. More diverse short-term humanitarian interventions in limited geographical areas could have been implemented during this crisis to reduce

excess morbidity and mortality. To remain within the humanitarian mandate, these interventions should be targeted at the most affected areas, defined by high food insecurity, high acute malnutrition and mortality rates, high HIV prevalence, lowest percentages of population access to health services, adequate sanitation and/or improved water sources. Other public health interventions during this period, such as immunisation, improved nutritional and epidemic surveillance, testing and improving water sources, health promotion and provision of basic primary health-care should have implemented. Without increased access to and improved performance of preventive and curative health services, people in southern Africa may have died and will continue to die from common and preventable diseases in both the short and long term, rather than directly from the consequences of food insecurity alone.

Conclusion

The core problem of the health sector gap in the 2002/3 southern Africa crisis lies in the failure of national governments and development initiatives to deliver successfully minimum levels of health services to their populations. The existing development framework has failed to provide access to health services to an adequate percentage of the population in southern Africa. This can only be accomplished with far greater resources, political will and specific action to address governance capacity. The Commission on Macro-economics and Health recently concluded that at least \$30–40 per capita per year are needed to run a properly functioning health system in the developing world (Sachs, 2001). These amounts far exceed the currently available health budgets for most of the populations in southern Africa (see Table 1). Increasing health-care provision for the poor in resource-constrained settings remains an international challenge (Jha and Mills, 2002; DCP, 2003).

Health, particularly the HIV/AIDS epidemic, played and continues to play, an intricate role in the southern Africa crisis. By improving basic primary health prevention and care as well as access to these services in the worst-affected areas, more lives may have been saved. Communicable diseases, preventable and easily treatable at a low cost, continue to affect malnourished and HIV/AIDS-affected populations. Complementary health interventions are needed to mitigate the impact of the crisis, to increase people's resilience and to enable economic growth. Health is not only an important economic factor contributing to people's well-being, but a fundamental human right (OHCHR, 1948, 1966).

Current health sector priorities in southern Africa should include the following:

- Develop or revise national disaster prevention and response strategies that support national health policies.
- Increase the overall access to a range of essential health services and drugs to prevent and treat common illnesses and opportunistic infections for all vulnerable groups.
- Ensure skilled professionals can continue to work in the public sector by improving working conditions, training and salaries.
- Expand the numbers of skilled professionals being trained to cope with AIDS-related attrition of health staff.

- Provide comprehensive health services for HIV/AIDS prevention and care, including anti-retroviral drugs when feasible (Kitahata et al., 2002).
- Strengthen civil society capacity to support community coping strategies, including home-based care for PLWH/As, reduction of stigma and care for orphans.

These actions require exceptional action and co-operation between humanitarian and development actors, bridging the disconnect between what are labelled ‘humanitarian’ or ‘development’ needs (Slim, 2000). Of course, the interface between relief and development, and calls for better links between them, has a long and rather unsuccessful history (Buchanan-Smith and Maxwell, 1999). The last decade has also seen a series of important criticisms of the linking-relief-and-development debate. Macrae (2001) argues that preserving the distinction between humanitarian and development aid is crucial to maintaining the integrity and technical efficacy of each. The issue is thus not as straightforward as thinking of ways that relief and development can simply be better linked. Rather, there are strong arguments for maintaining the distinctiveness and clarity of humanitarian aid. Indeed the very failure of development to deliver adequate health services in southern Africa, arguably strengthens the need for humanitarian assistance to remain distinct and subject to different rules that govern development assistance (Macrae, 2002).

The health sector gap in the 2002/3 southern Africa crisis suggests that these connections are not yet being made. This article has argued that there should have been an expanded humanitarian health response to the southern Africa crisis and that labelling inadequate access to health services as a development issue, and then largely ignoring it, is not acceptable. Moving beyond this will require renewed efforts on the part of donors and humanitarian agencies to move beyond a narrowly food-focused response to emergencies and develop broader methods for conceptualising and analysing needs. Given the complexity that HIV/AIDS adds to individual and community vulnerabilities and coping mechanisms, a broad-based multisectoral analytical framework that evaluated all sectors of public health needs to be developed and utilised. An urgent dialogue is needed to develop a robust strategy that will ensure improved and sustainable performance of the health system. This policy dialogue must build coalitions between the different international organisations and national stakeholders (de Waal, 2000). Furthermore, more research into the interactions of how the HIV/AIDS epidemic affects individuals’ and communities’ food security, health status and behaviour, and access to public health interventions needs to be undertaken.

Almost 30 years ago, the Alma Ata declaration stated that ‘the existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries’ (ICPH, 1978). The crisis in southern Africa shows that health inequalities are only increasing. As the HIV/AIDS epidemic spreads and matures in other parts of Africa and in the rest of the world, these inequalities will worsen.

Acknowledgement

I would like to thank the ODI study team by whom I was invited to the needs assessment case study in southern Africa, which inspired the writing of this paper:

James Darcy, Adele Harmer and Fiona Watson. I would also like to thank Egbert Sondorp for his valuable comments on an early draft of the paper.

References

- Baylies, C. (2002) The Impact of AIDS on Rural Households in Africa: A Shock Like Any Other? *Development and Change* 33(4): 611–32.
- Boudreau, T. (1998) *The Food Economy Approach: A Framework for Understanding Rural Livelihoods*. Relief and Rehabilitation Network Paper 26, Overseas Development Institute, London.
- Bradbury, M. (1998) Normalising the Crisis in Africa; paper presented at The Emperor's New Clothes? Uncovering the Collapse of Humanitarian Principles seminar. Disasters Emergency Committee; see <http://www.jha.ac/articles/a043.htm>, accessed 11 March 2003.
- Buchanan-Smith, M. and S. Maxwell (1994) Linking Relief and Development: An Introduction and Overview. *IDS Bulletin* 25(4): 3–9.
- Chanje, D. (2002) Nutrition Surveys in Thyolo and Mulanje Districts, Malawi. Oxfam, Lilongwe.
- Darcy, J., A. Harmer, A. Griekspoor and F. Watson (2003) Measuring Humanitarian Needs: A Critical Review of Needs Assessment Practice and Its Influence on Resource Allocation. Report of the case study on the southern Africa crisis, Overseas Development Institute, London.
- DCPP (2003) Disease Control Priorities Project. Working paper series. WHO, World Bank, Fogarty Intl Center and NIH. See <http://www.fic.nih.gov/dcpp/wps.html>, accessed 14 March 2004.
- De Waal, A. (1989) Famine Mortality: A Case Study of Darfur, Sudan. *Population Studies*
- (ed.) (2000) Democratic Political Process and the Fight Against Famine. In A. de Waal (ed.) *Who Fights? Who Cares? War and Humanitarian Action in Africa*. Africa World Press, Asmara.
- and A. Whiteside (2003) New Variant Famine: AIDS and Food Crisis in Southern Africa. *Lancet* 362: 1234–37.
- DHS (2000) *Malawi Demographic and Health Survey 2000*. Macro International, Calverton.
- Dyson, T. (1991) On the Demography of South Asian Famines. *Population Studies* 45(1): 5–25.
- Fedida, G. (2003) Disparate Responses to Need in Southern Africa. *Field Exchange* 18; see <http://www.reliefweb.int/w/rwb.nsf/0/418e61f6201d526385256d21004e5b5d?OpenDocument>, accessed 29 October 2004.
- Harvey, P. (2003) HIV/AIDS: What are the Implications for Humanitarian Action? A Literature Review (draft 1). Overseas Development Institute, London.
- IASC (2002) Guidelines for HIV/AIDS Interventions in Emergencies. Interagency Standing Committee Reference Group on HIV/AIDS in Emergency Settings, Geneva.
- ICPH (1978) Declaration of Alma Ata. International Conference on Primary Health Care, 6–12 September, Alma Ata.
- Jaspers, S. and J. Shoham (2002) A Critical Review of Approaches to Assessing and Monitoring Livelihoods in Situations of Chronic Conflict and Political Instability. Working Paper 191, Overseas Development Institute, London.
- Jha, P. and A. Mills (2002) Improving Health Outcomes for the Poor. The Report of Working Group 5 of the Commission on Macro-economics and Health. World Health Organization, Geneva.
- Kitahata, M.M., M.K. Tegger, E.H. Wagner and K.K. Holmes (2002) Comprehensive Health Care for People Infected with HIV in Developing Countries. *BMJ* 325(7370): 954–7.
- Loevisohn, M. and S. Gillespie (2003) HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding. The Hague, IFPRI, ISNAR and RENEWAL; see http://www.sarpn.org.za/mitigation_of_HIV_AIDS/m0027/Renewal_WP2.pdf, accessed 11 June.

- Macrae, J., (2001) *Aiding Recovery? The Crisis of Aid in Chronic Political Emergencies*. Zed, London.
- , S. Collinson, M. Buchanan-Smith, N. Reindorp, A. Schmidt, T. Mowjee and A. Harmer (2002) *Uncertain Power: The Changing Role of Official Donors in Humanitarian Action*. Humanitarian Policy Group Report Number 12, Overseas Development Institute, London.
- Maxwell, D. (1999) Programmes in Chronically Vulnerable Areas. Challenges and Lessons Learned. *Disasters* 23(4): 373–84.
- MOH and WHO (2002) Rapid Needs Assessment for the Health Sector in Zimbabwe. Humanitarian Assistance and Recovery Programme, Ministry of Health and Child Welfare. World Health Organization, Harare.
- MOHP and WHO (2002) Report on the Rapid Health Assessment to Establish the Impact on Human Health Caused by the Food Crisis of 2001–2002 in Malawi. Ministry of Health and Population and World Health Organization, Lilongwe.
- Morris, J. (2002). Mission Report: Lesotho, Malawi, Mozambique, and Swaziland, 3–15 September, United Nations, Rome.
- and S. Lewis (2003) Mission Report: Lesotho, Malawi, Zambia, and Zimbabwe 22–9 January, United Nations, Rome.
- MSF and WHO (2003) Antiretroviral Therapy in Primary Health Care: South African Experience, Médecins Sans Frontières, World Health Organization, Cape Town; see <http://www.accessmed-msf.org/documents/ARVSouthAfricaexperience.pdf>, accessed 14 August 2003.
- OHCHR (1948) Universal Declaration of Human Rights, Article 25. Office of the High Commissioner for Human Rights, Geneva; see <http://www.unhchr.ch/udhr/lang/eng.htm>, accessed 14 March 2003.
- (1966) International Covenant on Economic, Social and Cultural Rights, Article 12. Office of the High Commissioner for Human Rights, Geneva; see http://www.unhchr.ch/html/menu3/b/a_ceschr.htm, accessed 2 April 2003.
- RIACSO (2003) Regional Consultation on Humanitarian Assistance Needs in Southern Africa: Maintaining the Momentum. UN Regional Inter-Agency Coordination Support Office Johannesburg; see <http://www.reliefweb.int/w/rwb.nsf/480fa8736b88bbc3c12564f6004c8ad5/667e05698e884527c1256d5d00354f70?OpenDocument>, accessed 12 July.
- (2003) Southern African Humanitarian Crisis update, 16 Jul 2003, UN Regional Inter-Agency Coordination Support Office; see <http://www.reliefweb.int/w/rwb.nsf/480fa8736b88bbc3c12564f6004c8ad5/02f1d2f1ec13bf50c1256d6b00486063?OpenDocument>, accessed 25 August.
- Sachs, J. (2001) Report of the Commission on Macroeconomics and Health. World Health Organization, Geneva.
- Slim, H. (2000) Dissolving the Difference between Humanitarianism and Development: The Mixing of a Rights-based Solution. *Development in Practice* 10(3 and 4): 491–4.
- Stabinsky, L., K. Pelley, S.T. Jacob, J.M. Long and J. Leaning (2003) Reframing HIV and AIDS. *BMJ* 327: 1101–3).
- Steering Committee for Humanitarian Response (2003) The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response. Sphere Project, Geneva.
- Taifour, H. (2002) Nutrition Survey Report: Salima and Mchinji districts, Malawi. Ministry of Health and Save the Children-UK, Lilongwe.
- Tawfik, L. and S. Kinoti (2001) The Impact of HIV/AIDS on the Health Sector in Sub-Saharan Africa: The Issue of Human Resources. SARA project, USAID/AFR/SD, Washington.
- UNAIDS (2002) Report on the Global HIV/AIDS Epidemic. UNAIDS, Geneva.
- UNDP (2002) Human Development Report 2002. United Nations Development Programme, New York; see <http://hdr.undp.org/reports/global/2002/en/>, accessed 11 March 2003.
- Unicef (2002) Preliminary Report of 1st Round of District Nutrition and Mortality Surveys in Malawi, August/September, Unicef, Lilongwe.
- UNOCHA (2002a) United Nations Consolidated Appeal in Response to the Humanitarian Crisis in Southern Africa: Lesotho, Malawi, Mozambique, Swaziland, Zambia, Zimbabwe, July

- 2002– June 2003. UN Office for the Coordination of Humanitarian Affairs, New York and Geneva; see <http://www.reliefweb.int/w/rwb.nsf/s/697758EF9099E9FAC1256BFA004A6EEB>, accessed 14 March 2003.
- (2002b) United Nations Consolidated Appeal in response to the humanitarian crisis in southern Africa: Zimbabwe, July 2002–June 2003. UN Office for the Coordination of Humanitarian Affairs, New York and Geneva; see <http://www.reliefweb.int/w/rwb.nsf/480fa8736b88bbc3c12564f6004c8ad5/e047a96fbc2b164ac1256bfa0058aa9d?OpenDocument>, accessed 14 March 2003.
- (2002c) United Nations Consolidated Appeal in Response to the Humanitarian Crisis in Southern Africa: Malawi, July 2002–June 2003. UN Office for the Coordination of Humanitarian Affairs, New York and Geneva; see <http://www.reliefweb.int/w/rwb.nsf/480fa8736b88bbc3c12564f6004c8ad5/0fbabfd46461e32cc1256bfa00524285?OpenDocument>, accessed 14 March 2003.
- (2004) An Assessment Framework and Matrix for the Consolidated Appeal Process Developed by the Interagency Standing Committee's Sub-working Group for the Consolidated Appeal Process. Available through the OCHA CAP unit, Geneva.
- Valid International (2003) A Stitch in Time? Independent Evaluation of the Disasters Emergency Committee's Southern Africa Crisis Appeal, July 2002–June 2003, London.
- WHO (2002) World Health Report 2002; Reducing Risks, Promoting Healthy Life. WHO, Geneva.
- WHO (2003) The Three-by-five Initiative: Treat 3 Million people living with HIV/AIDS by 2005. World Health Organization, Geneva; see <http://www.who.int/3by5/en/index.html>, accessed 30 March 2004.
- Zimbabwe VAC (2002) Zimbabwe Emergency Food Security Assessment Report. Zimbabwe Vulnerability Assessment Committee, 16 September, Harare.

Address for correspondence: Andre Griekspoor, Health Action in Crises Department, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland. E-mail: <<griekspoor@who.int>>