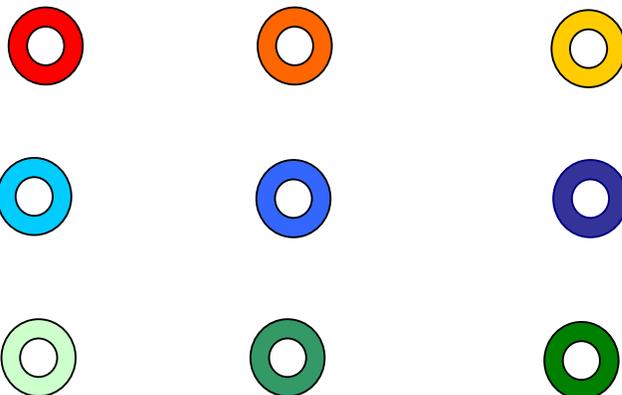# Consultative Meeting of Health Action in Crises (HAC) /Emergency Humanitarian Action (EHA) Focal Points for Southern Africa:

18 to 20 November 2003, Lusaka Zambia

Report on Proceedings and Key Issues

EXECUTIVE SUMMARY

In order to improve health interventions in the current Southern Africa Humanitarian Crisis, on 18-20 November 2003 WHO/HAC convened, in Lusaka, a three-day consultation meeting for the six most affected countries in Southern Africa. Participants included HAC Focal Points from WHO Country Offices in the 6 countries, HAC/ICT-Harare, RIACSO, other sub-regional HAC Focal Points, AFRO and HAC/HQ. The objective of the meeting was to provide orientations and develop a plan to improve health interventions in Southern Africa countries affected by the current humanitarian crisis.

Health Action in Crises was identified as a cross cutting issue, that had implications for all members of the WHO Country Team .

The objectives of the meeting were satisfactorily achieved. The following conclusions and recommendations were made:.

- The SAHC was a really serious crisis with multiple causes
- HIV/AIDS was an emergency and therefore unusual and exceptional responses/action were required to address it.
- There was a common position on the desirable WHO response to the Crisis – to work closely with national Governments and other partners to identify and address the threats of epidemics and malnutrition, limiting priories up to five.

- To expedite implementation of activities, stickers would be issued on at least a quarterly basis, based on the countries' or sub-regional plans submitted to AFRO, at the same time ensuring improvement of mechanisms for monitoring and accounting for the use of the funds provided.

- To improve on HAC effectiveness and efficiency, there was need for capacity-building at WCO level, including the recruitment of full-time HAC Focal Points

- EHA/HAC was a cross-cutting issue, across all Units, Departments and sectors within and outside WHO – hence partnership was critical

- Be results-oriented
- Evidence-based decisions (Information was critical, and integrated/collaborated assessments across the sectors recommended for comprehensiveness)

If WHO was to earn the right to lead the health sector, it was more important to try to 'do the right thing' rather than play safe by only 'doing things right'. Risks needed to be taken, but it was important to minimise them by not breaking rules where it is not necessary to do so.

Introduction

In order to provide orientation and a plan to improve health interventions in the current crisis in Southern Africa, a consultation meeting was organised in Lusaka on 18-20 November, 2003, for HAC Focal Points from the six most affected countries in Southern Africa; HAC colleagues from HQ, AFRO and other sub-regional HAC FPs. The following were the objectives of the meeting:

- To present the current health situation, emergency programmes and achievements in the Southern African countries.

- To identify critical health challenges in humanitarian situations, including technical gaps.

- To agree on sub-regional priorities for EHA for the biennium 2004-2005 plus one.

- To receive a briefing on WHO/DFID assessment and follow-up.

This report serves as a summary record of the consultation. Further to actively engage the reader in the learning process, nine questions have been inserted at different points in the summary report to reflect what appeared to be the cumulative flow of understanding that developed. These questions are highlighted by a coloured 'donut'. These serve as thought-provoking as Albert Eisten (a famous writer) once said: "Answers are not important. It is the questions that really matter.

Introductory Session:

- Dr Anikpo (DES/AFRO) opened the session welcoming everyone and briefly outlining the reasons for holding the meeting and that we needed to accept new ways of working

- Dr Nabarro (HAC/HQ) referred to the recent WRs' meeting in Geneva which recognised the importance of emergency management and the critical role the WCOs play. He stated that WHO's success hinged on performance at WCO level. He said that our main role was to assist Governments and communities minimise the effect of crises on health.

- Dr Anyangwe (WR/Zambia) stressed the importance of emergency activities. She noted that the current crisis in SA started as a food crisis, but had now become a wider issue encompassing all sectors linked by HIV/AIDS. She noted that in the Zambian context, provision of ARVs made economic sense and that EHA/HAC and RPA *must* work together in tackling the situation.

- Dr Anikpo then put the meeting into an African context noting that although only 10% of natural disasters occurred in Africa, 60% of resultant deaths were in Africa. She listed the financial impact of disasters and their impact on health systems and a variety of health related indicators. She noted the general inadequacy of the response and outlined WHOs role in supporting the response. She finished by outlining the objectives of the meeting.

Why do Africans bear such a disproportionately large share of disaster related mortality?

- It was noted that another WHO consultation was happening simultaneously in the same hotel, on the WHO Director General's (DG's) "Three by Five" initiative, and a wish was expressed for some opportunity for dialogue with that process. Since scaling up ARV based care for HIV/AIDS patients was considered a critical component in the response to the Southern African Humanitarian Crisis. (No formal exchange sessions were possible however, but informal exchanges were made with some participants during meals.)

- A special request was made to have some input on the Secretary General's Special Task Force on Women, Girls and HIV/AIDS. This was scheduled into the programme.

- Presentations . Nutrition in Crisis Situations

- Dr Sagbohan (AFRO/NUT) made a presentation on nutrition in crises. He outlined the major nutritional deficiencies in emergency situations. Discussing issues relating to assessment of the nutritional situation, he noted some of the challenges and listed the main nutritional interventions.

- Issues relating to nutrition in the context of HIV were discussed and it was agreed that WHO must give very strong and clear guidance in this area.

- Health Action in Crises. Emerging Strategic Priorities for WHO

- Dr David Nabarro reported on the new DG's views and vision: Must do better in empowering the Country Team to lead; everyone is involved; must provide guidance when asked..

- "EHA" was too vague and 'corrupted' term. "Health Action in Crises" adopted to emphasise focus (health) urgency (action rather than debates) and state of systems (crisis)

- Briefly analysed WHOs performance to date and concluded by stating that there is still room for improvement

- In response to request from Member States, Director General has requested rapid development of an organization-wide HAC strategy (See Appendix 1 for current draft of the strategy.)

- Shared proposed strategic goal and three major objectives

- Organisational change

- In-country focus on crises

- Work with local and national systems.

Issues

- Outlined where, what, when and how of WHO's proposed contribution

- Action in absence of capacity

- Key activities for WHO

- Inputs on WHO's performance and suggested way forward were made from the floor, namely…………………………

Country Presentations: Summary

- Each of the six countries presented a report on the current HAC priorities and challenges being faced. The reports focused on:-

- HIV, Malaria and TB

- Malnutrition

- Diarrhoeal diseases including cholera and other infectious diseases

- Other issues related to poverty and poor socio-economic (Access and QoC)

- Maternal, child and reproductive health

- Epidemiological skills

- EPR capacity

- Responses to the needs differed by country but challenges and priorities were remarkably similar. Common issues among the countries were:-

- Qualified and capable personnel were hard to recruit and retain leaving both national health systems and WHO Country Offices with inadequate capacity.

- Profile of Emergency Preparedness and Response in countries was low, and patchy.

- Poor data availability and usage

- Resource inadequate

- Need for increased flexibility within WHO to ensure timely response to emergencies/disasters.

- Motivation and moral of remaining Health Care Workers was low.

Have we earned or are we earning the right to lead in the Southern African crisis?

In **responding** to the presentations, David Nabarro noted the following:

- We *do* have a common position on different aspects of the Crisis

- It is a really serious crisis with multiple causes

- There is a particular pattern of vulnerability associated with the crisis (« Hot Spots », Poor most at risk)

- Health services are deteriorating in the Crisis

- The increasing number of orphans is worrying

- We know the main threats to health and optimal interventions to tackle them

- Stakeholders want our guidance on optimal health investments: can we help them?

- Nutritional assessments – significance of acute and chronic malnutrition and appropriate responses is important?

- The current deteriorating status and performance of the health system

- The correct WHO contribution to reduce threats to health – now and in the longer term

- We *do* have a common position on the desirable WHO response to the Crisis

- Working pro-actively with National Governments and civil society to assess, map, monitor vulnerability

- Contributing to, and working within the context of, the UN system-wide response co-ordinated via RIACSO (Are we consistent in our handling of RIACSO and associated tensions)

- Identifying health priorities and supporting prioritised health action by all stakeholders, e.g.

    - HIV Prevention and ARV-based AIDS care (ARVAC)

    - Food and Nutrition

    - Malaria, TB

    - Maternal and Reproductive Health, Child Health, Gender-based violence

    - Diarrhoea and other faeco-oral diseases; cholera

    - Trauma, injury management, first aid

    - Mental Health

- We *do* have a common position on how to repair damaged Health Systems

- Functional health systems are ABSOLUTELY CRITICAL for the future of the nations

- RESULTS matter: Systems must deliver ARV-based AIDS care and pay attention to women's health,

- Seek ways to involve community groups ever more in health action, work with and through NGOs;

- Locate strategic health facilities and critical health workers, valuing their contribution, encouraging them to continue working effectively,

- Improve communications (phone, radio, e-mail),

- Concentrate on 4 or 5 priorities

- Work with stakeholders at local level to identify "HOTSPOTS" and concentrate on up to 5 priorities

- Establish a partners' group to monitor health sector progress

- Establish Health Action in Crises capacity in country

- We agree on priorities for Health Action in Crises in Southern Africa

- WHO is trying to work with partners for better health action and outcomes:

    - we must be credible enough to co-ordinate;

    - skilful enough to lead

- We need to continue putting emphasis on

    - Situation assessment (information and analysis)

    - Agreed strategies, targets and coordinated implementation (stakeholders)

    - Ensuring essential inputs are made available (people, logistics and supplies)

    - Capacity building for crisis management in country

    - Tracking progress

    - Monitoring progress and Communicating information

    - Maintaining excellent relations with donors

- WHO as a whole, the HAC team in particular – who does what?

- What does EHA/HAC do, what does WHO do?

- In practice all WHO's work in a crisis setting is HAC work

- The HAC/EHA team provides functional support to the WHO country team in this exceptional situation

    - Importance of good situation assessment

- Importance of lesson learning…

- Importance of clear agreement between WR and EHA/HAC people, units and departments

- How much research is needed???

Overnight Reflections.

- Dr. D Nabarro chaired the morning and invited observations and reflections from the floor, in response to Dr. Drysdale's concise summary of the previous day's proceedings. Key issues that came out during discussions were;

- EHA/HAC should be a crosscutting issue and staff at all levels need to understanding and accept this priority, provide support and showing flexibility in implementation of administrative procedures.

- In response to discussion on the need for innovation and change in the way WHO has tended to operate, David Nabarro emphasised that if WHO was to earn the right to lead the health sector, it was more important to try to 'do the right thing' rather than play safe by only 'doing things right'. This implied strategic effectiveness as well as operational efficiency. He advised however that precautions be taken to ensure that someone higher up in the organisational hierarchy was informed and could back one up, when one felt a situation required one to over-ride established rules and procedures, in order to 'do the right thing'. Risks needed to be taken, but it was important to minimise them by not breaking rules where it is not necessary to do so.

- Dr. Anikpo acknowledged that HAC staff experienced frustration with the bureaucracy of WHO, and added that it was planned to run HAC orientation workshops with staff at different levels within WHO and Government partners, which would hopefully sensitise them to the urgency required of them by HAC, and thus create a climate for better support.

How well is WHO realigning itself to do the right thing in the right places?

Health Assessment in Crises

Effective Health Action presupposed reliable and appropriate Assessment in Crisis. Dr Andre Griekspoor (MO/HAC/WHO/HQ) and Dr Sean Drysdale (EHA/ICT Epidemiologist), reviewed the purpose, process and status of Health Assessment in the Crisis.

- Dr. Andre Griekspoor explained WHY Health Assessment in Crisis was important.

- Good humanitarian donorship initiative

- Consolidated appeal process

- Strategic priorities

- Involvement of key partners is very critical

- HA should be a basis for continuous process of

- Monitoring progress and changes

- Evaluation

- Discussed strengths, challenges and difficulties

- Dr. Sean Drysdale Presented the status of Health Impact Assessments (HIA) in Southern Africa.

- 4 countries completed fieldwork.

- Difficulties encountered- timeframe, workload and capacity at country offices

- Next steps are to utilize the information for WCO planning, sharing the lessons learned, complete assessments in remaining 2 countries, follow-up surveys for over 2-3 years, involve other stakeholders.

- In response to the discussion, Dr Nabarro offered the following comments.

- We need information to both guide action and appeal for resources. INFORMATION IS GOLD: « EVIDENCE YIELDS THE FUNDS

- HAC personnel need to explain how the WHO assessment fits with other assessments, to provide a more comprehensive picture. It was important to show trends, which implied starting early, and tracking changes in important indicators.

- Judgment had to be made to get the optimal balance and trades-off between.

  - working with a range of partners vs getting what is needed for health;

  - biomedical vs broader determinants;

- comprehensiveness vs speed;
- tight control of data vs informing the clients quickly

HIV/AIDS in Southern Africa:

Dr. Emil Asamoah-Odei (MO/DDC/RPA/AFRO)

- Presented the extent of HIV/AIDS problems particularly focusing on southern Africa.
- Women/girls are the worst sufferers
- Impact on the mortality, life expectancy, orphanhood, productivity and on various sectors like- health, agriculture, education
- HIV/AIDS- deepened the current crisis
- HIV/AIDS is both the cause and consequence of the food shortage

Dr Namposya Nampanya – Serpell: UNAIDS Country Coordinator- Zambia

- Described the work and TORs of the UN Secretary General (UNSG) Task Force on women, girls and HIV/AIDS.
- The thematic areas of focus of the task force are:
- Prevention of HIV infection among girls and young women;
- girl's education;
- violence against women and girls;
- property & inheritance rights of women and girls;
- role of women & girls in caring for those infected & affected by HIV/AIDS;
- and access to HIV/AIDS care & treatment for women and girls

Summary of discussion

- HIV/AIDS is an emergency…unusual and exceptional action is needed
- Gender disaggregating has to be at the centre of assessments
- Focus for action should be the crisis hot spots and issues faced by women need to be at the centre of the health work in these high impact hot spots
- Action should also include
- support (to men and women) for sexual and reproductive health
- Essential package of health care, accessible to women, to cover all common conditions
- Nutritional counselling and support
- ARV-based AIDS care

How well is WHO contributing to changing the UN Systems response to the Southern African Humanitarian Crisis from an efficient WFP led food emergency to a comprehensive and effective public health response to chronic underlying conditions (accelerating HIV infection, rising mortality due to AIDS/poverty, weak governance and institutional failure)?

HAC Funding Issues:

DFID/WHO Common Assessment- Dr. Andre Griekspoor, HAC HQ.

The meeting was briefed on the findings of the joint DFID/WHO review that was conducted in April/May 2003 on DFID support to WHO/HAC.

- Main findings were generally positive.
- Main constraints identified were

- slow WHO recruitment procedure,

- weak general management,

- over-ambitious planning

- progress and financial reporting require strengthening

- Need to mainstream humanitarian responsibility in overall WHO areas of work

- A three-year planning period was suggested to provide more realistic timeframe.

Utilization of Extra Budgetary Funds - Dr. K. Siamevi (AFRO/EHA)

- Current problems of funding:

- Not able to use money in time

- Do not know the exact situation of the funds in allotments

- Not always reporting accordingly to donors

- The funds are not utilized in appropriate way

- Causes

- The use of funds is not well planned in advance.

- Insufficient staff to implement activities

- Slow recruitment and purchase procedures

- No follow-up of agreement, allotments and issuance of stickers

- Difficulties to deal with the national authorities

- And finally he discussed about what to do at various levels to overcome these problems

Discussions on the presentations

- Planning and fund utilization is a collective responsibility

- The issue of stickers should be decentralised to the country or local office level – eg on a quarterly basis based on agreed plans

- need to introduce a proper project management approach with standard operating procedures

- Project Implementation Plan to be developed before project is submitted

- Making Sense

How can we become more operationally efficient in use of resources, and work together better with stakeholders, to increase our strategic effectiveness?

Empowerment for Long Term Health

Vulnerability Assessment - . Youcef Chellouche (AFRO/Technical Officer)

- He described the process of vulnerability assessment, definitions, planning group, hazards- identification/techniques/ characteristics, community characteristics, effects, and qualitative matrix along with recommended actions.

Scenario Planning - Dr. Anthony Mawaya (STP/LHD/DES/AFRO)

- Scenario Planning was a "Strategic" Approach which included the following components

- - Strategic Diagnosis: past and present situation analysis using the SIM?

- - Strategic Diagnosis: future situation analysis using Scenarios

- - Strategic Goal-setting: The Need for a Vision

- - Strategy Formulation

- - Operational Planning

- He concluded that the EHA/HAC strategies, policies and plans should be forward-looking long-term propositions requiring scenarios and Vision, and

- The strategies should be built on a solid foundation of relevant strategic information collected through analysis of past, present and future situations in both the internal and external environment.

Discussions on presentations

- Training on Vulnerability Assessment is planned for next year

- It was noted that Shell Oil had used the visioning and scenario development approach in determining its response to the impact of HIV/AIDS in Southern Africa on its markets. It was reported that they had given permission to WHO to circulate their report as it provided an example of the Scenario Planning methodology, as well as an analysis of the driving forces of HIV/AIDS.

- Strategic approach for crises response with longer term proposition

- The scenario planning approach may be used in CAP planning

CAP Process in SA: where are we? - Dr. G Mulugeta (EHA/ICT Coordinator)

- Summarized the CAP for 2003-2004 for Southern Africa

- Indicated some of the shortcomings e.g. needs and areas identification are not focused, overlap of proposals by agencies

- Mid-term review will provide opportunity to review, revise and update our funding priorities

Discussion:

- Need to be proactive, plan ahead rather than waiting for the last moment

- Possibility of getting money is very slim unless special effort is made

- Fund ing through CAP is very competitive, consider partners and competitors and, donors

How could we refine, develop and contribute our knowledge and understanding of HAC, to ensure both immediate intervention and best prospects for recovery and long term health?

Planning for the future.

Three Year Action Plans

By the end of the meeting, a three-year HAC action plan was developed for adaption and by the WCOs and sub-regional Offices, as well as a tool for resource mobilisation.

- DFID had offered to continue funding HAC in Southern Africa provided a three year plan of action was formulated for 2004-2006. Three groups were formed and given an exercise to each develop a three year action plan for a typical country in Southern Africa.

- The 3 groups presented their work plans in the plenary. The main areas covered were WHO leadership role in crisis, HIV/AIDS, Coordination, Nutrition, Information for planning and decision making, control of communicable diseases in emergency.

- The presentations were followed by discussions, and guidance from Dr. Anikpo for future orientations. It was agreed that the ICT/ Southern Africa would consolidate the groups' plans of action into one generic plan and disseminate to the countries by Monday, 24th November, 2003. Following which the countries have to finalize their work plans and send them to AFRO by the end of the week (28th November). AFRO would approve and use the plans to issue stickers.

How can we make best use of DFID's offer of support in the next three years?

Additional recommendations.

- The most challenging activities were to be planned for 2004 to 2005

- For extra budgetary funds, concentrate on areas where HAC would make a difference

- The objectives in the action plans should be Specific, Measurable, Attainable, Realistic and Time-bound (SMART)

- AFRO to develop generic TORs for HAC focal point in order to avoid duplication and conflict with, DPC with regard to CSR activities. See Appendix 3.

- Proactiveness in recruitment of staff to be done well in advance.

Follow Up Actions

- Staffing: remains the most challenging aspect for the WCO, Sub-regional and AFRO and there is an urgent need to address this.

- Training: Conceptualization of the training sessions to update the skills of the HAC staff.

How can we take this experience of learning forward?

- Resource/Fund Mobilization: Contribution and Role of WCO, Sub-regional and AFRO levels in HAC. This involves the reporting of activities to HQ.

- RD commitment to HAC: AFRO will organize regional induction briefings for divisions and units on HAC to encourage them to mainstream HAC in their programmes.

- Need for demand driven assistance to countries and aggressive but diplomatic involvement with other partners and agencies in HAC.

- In conclusion she expressed special thanks to DDC and DNC Units of AFRO, HQ Colleagues, Dr. David Nabarro and Dr. Andre Griekspoor, WR Zambia and her team for their hard work in preparation for this meeting, logistical support and participation.

Conclusion

What examples do we have in our Country Teams to inspire us to bold Health Action in Crises?

P.S. The only way to connect the nine dots is to 'think outside the box'
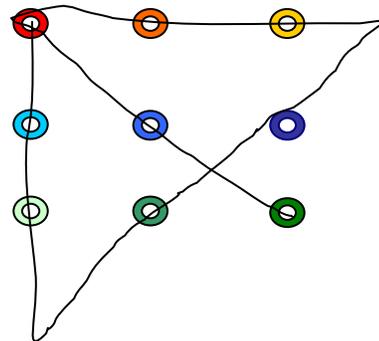
Another quote offered by Dr Drysdale during his summing of day one, provides a fitting conclusion.

> It is not the critic who counts, not the one who points out how the strong man stumbled, or how the doer of deeds might have done them better. The credit belongs to the man who is actually in the arena; whose face is marred with sweat and dust and blood; who strives valiantly; who errs and comes short again and again; who knows the great enthusiasms, the great devotions and spends himself in a worthy cause and who, if he fails, at least fails whilst bearing greatly so that his place shall never be with those cold and timid souls who know neither victory nor defeat.

Theodore Roosevelt

Closing Remarks

- Dr. Anikpo in her closing remarks, on behalf of the secretariat, firstly expressed her appreciation for the efforts made by WCOs and ICT in managing the compound crisis (HIV/AIDS, Food Shortage, Poverty and Health System deterioration) inspite of limited human and financial resources. She also stressed that there was a need to improve in making objectives and actions focussed.

- With regard to the outcome of the meeting, she said the quality of the draft plan of action produced by the 3 groups was good.

Health Action in Crises: Strategic Priorities for the World Health Organisation

Version 6.2: November 12th 2003

A   Background:

A crisis is a result of systems being overwhelmed: People are exposed to a crisis when local and national systems are unable to meet their basic needs. This is usually because the systems are overwhelmed – either because demands increase suddenly, or because the systems are breaking down (or both). System break down may be because the underpinning institutions (such as government ministries or local authority departments) are weakened.

Crisis resolution and prevention through system strengthening: A crisis will resolve when systems have been mended and are strong enough to withstand these demands. And crisis may be prevented or mitigated if systems have been developed in a way that anticipates factors that trigger crisis (such as earthquake resistant infrastructure, or contingency planning adopted as a routine) and are resilient enough to handle the majority of them

Crisis triggers: Crisis may be triggered by
- sudden catastrophic events – like earthquakes and hurricanes;
- complex and continuing emergencies – over 100 violent conflicts, and associated displacement;
- slow-onset processes – widespread arsenic poisoning in Ganges delta, or increasing prevalence of fatal HIV infection in Southern Africa.

Crisis affects billions of people: As many as two billion people in more than 50 countries face threats to health because they are at risk of being exposed to crises conditions. They experience high rates of suffering and death: principally as a result of common illnesses made more dangerous by crisis conditions. Vulnerable groups experience excessive suffering, and their deaths rates are unnecessarily high. It will be hard to ensure equitable development and to realise the Millennium Development Goals if the health aspects of crisis do not receive their share of attention

Preparation for health aspects of crisis could be better; response to health crises is unreliable: Generally, the ability of local and national authorities to prepare for the health aspects of crises is not as good as it could be.   But the quality of national and international responses to risks to health during crises is unreliable. Too often, vulnerable groups experience excessive suffering, and deaths rates are unnecessarily high.

WHO is developing an organisation-wide strategy for health action in crises: WHO's Member States have requested the Organization to pay increased attention to the health aspects of crises, and to contribute to better crisis preparedness and more rapid response, especially within countries. The Director General has responded with a process for the rapid development of an organization-wide strategy for better Health Action in Crises (HAC), capacity building within HAC co-ordination units in regional offices and headquarters, and the full engagement of technical and general management departments in supporting HAC work throughout the organisation. WHO funding partners want WHO to provide direction and demonstrate leadership: WHO is committed to the production of a new HAC strategy and operational plan by December 1st 2003.

B   Proposed Strategic Goal:

> WHO is reliable and effective in supporting communities and health stakeholders as they prepare for, and respond to, the health aspects of acute and long-term crises so as to minimise suffering and death and, open the way to the recovery of sustainable healthy livelihoods.

C   Proposed Strategic objectives:

Within two years WHO will have the following capacities:

- **All WHO has a focus on crises**: All of WHO's work and programmes will take account of the potential for, and consequences of, people's health being affected by crises, and contribute to a reduction of suffering through better anticipating the possibility of crisis conditions

- **WHO contributes to in-country capacity to prepare for, respond to and recover from** health aspects of crises. The intention is to ensure that all health stakeholders make co-ordinated efforts to reach agreed standards for best practice through WHO regional and headquarter groups offering an agreed level of service to country teams, so as to

a)   Help local and national systems prepare for and mitigate the potential effects of crises;

b)   Help mend and rehabilitate damaged systems and contribute to their recovery and reconstruction in ways that mitigate the effects of further crises, promote health equity and contribute to the realisation of development goals; and

c)   Maintain life and health when systems have failed. (Particular attention will be given to these objectives in crisis prone settings)

- **WHO's country teams will provide these services in ways that support national institutions, within the overall response by the international community.**

2)   **When demands on WHO country teams are acute, they will be able to draw on additional "surge" capacity accessible to WHO regional offices and headquarters.** This will be provided through the time-limited deployment of specially developed *WHO health crisis multidisciplinary response and recovery teams*.

D   Critical elements of the WHO contribution

WHO has an operational role in advance of, during and after crises, to ensure that there is adequate local-level capacity for specific functions:
WHO should ensure that – within a crisis prone and/or affected location – there is the capacity to implement best practice with regard to health aspects of crises, as follows:

1)   To assess situations in advance of or during crises, to analyse assessments and anticipate future events, to develop strategies, to implement and then review crises - in relation to health aspects of crises

- To obtain data, usually through others, on risks faced by and health situation of people in communities prone to, and affected by crisis – with a focus on trends, vulnerabilities and inequities;

- To analyse these data, develop scenarios and display them - at web sites, co-ordination centres and HIC;

- To analyse critical areas of the health system and identify main weaknesses that affect the capacity to address health needs and require immediate remedial action; and

- To monitor progress in responding to the crisis together with other sectors - and report results at regular intervals

- To ensure technical back-up for, and co-ordination of, effective preparation, mitigation, response and recovery

- To be there early, to engage partners, to access necessary inputs, and to help ensure that gaps are filled - to anticipate the possible health consequences of a crisis – to enhance the resilience of health infrastructures and systems, to optimize and enhance local and national response to crisis, to be ready to call for and absorb external assistance when needed;

- To convene actors and secure agreement on what is to be done;

- To co-ordinate implementation of action and fill gaps as necessary and monitor who does what;

- To enable policy people and implementers to access technical advice, systems and wider support as needed; and

- To have a rapid response and intervention capacity alongside other UN agencies working in crisis, using and enhancing whatever local capacity is available - as a part of the response to shattered coping systems.

- To work effectively with – and strengthen – the systems that influence health and are implemented via local or national institutions

- To convene different stakeholders, encouraging consensus on priorities and best practice, setting standards for health action, implementing life-saving interventions, and contributing to system repair and recovery within central and local government as well as civil society;

- Drawing on lessons from the past, and using this expertise, to prepare for, mitigate and improve responses to future crises; and

- Through working in this way, to contribute to the combined effort of the international humanitarian community … earning the right to lead on health sector issues.

Where the capacity does not exist WHO needs to be more proactive: WHO may need to ensure that gaps are filled – through encouraging other health actors to fulfil the role, or through undertaking vital operations itself.

E   Improving WHO performance:

WHO needs to change the way in which it works – not only within HAC and EHA departments, but within all concerned departments and units, at country, regional and headquarter levels. The following functions are critical elements of the cross-WHO service for health action in crises:

1)   **Ensuring effective linkages between country teams and technical programmes in regional offices and headquarters ("Programme support offices") on HAC issues**

   a)   This function is essential for getting the whole of WHO to focus on the reality of countries in crises – developing capacity, working with and through partners, and participating in the inter-agency response to crises:

   b)   It enables better co-operation among all departments within the Organization and facilitates co-ordination of different technical actors in emergencies.; and

   c)   It also helps all technical and administrative specialists within the organisation - and beyond – to recognise the importance given by senior management to crisis issues, and to adopt a "can do" attitude.

- **Providing operations support for HAC before and during crises:**

- This function gives priority to ensuring that all WHO offices and crisis response teams satisfy minimum standards of security, connectivity, transport capacity, cash handling and administration, logistics and supplies management, co-ordination capacity, media management and communication;

- The function also ensures access to satisfactory technical, administrative and logistic personnel, pre-trained and equipped, supported by simplified administrative procedures (one signature policy, revolving funds, together with systems for urgent money movement and rapid mobilisation of human resources); and

- The function requires a backbone of skilled people within WHO and a network of available professionals, ready to move at short notice, for preparatory work, assessment and implementation of responses, and support to system recovery.

- **Gathering Intelligence on Health in Crises and Learning Lessons of Experience**

- This function ensures that WHO tracks what is happening in pre-crisis and crisis settings, monitors and analyses progress, evaluates progress and learns from experience;

- It will also ensure that WHO provides effective training to its own staff, and those from other organisations, who are preparing for or responding to health aspects of crises.

- **Maintaining effective working relationship with partners for Health Action in Crises**

- This function leads to effective working relationships between WHO and other regional and international groups committed to more effective health outcomes for people at risk of – and affected by – crises;

- It includes full participation in UN system processes at country and international level – especially OCHA and ECHA, effective working with NGOs – especially the Red Cross Movement and with bilateral agencies; and

- It includes involvement with the IASC and its associated bodies, and the CAP process and transition issues, and close working relations with other agencies committed to health action, especially UNICEF.

- **Communicating HAC Information to Key Audiences**

- This function ensures that available information is made available in ways that help different groups (funders, development workers, NGO staff, specialists from other sectors and other stakeholders) understand the issues

- It also helps them appreciate the potential to achieve meaningful results, and share views through debate and discussion – in person, via video- or tele-conferences, and on the Web; and

- It should also encourage attention to Crisis Preparation and Response issues by members of the Executive Board and Regional Committees, and other international bodies.

- **Mobilising Resources for HAC; management, tracking and reporting on use of these resources**

- Working within the context of the Consolidated Appeal Process, WHO will work to mobilise critical resources for health, distributing these resources to national and international bodies and across agencies as per agreed strategies; and

- WHO will track their onward distribution, managing their utilisation, and reporting on results obtained.

Executive Summary

This study was commissioned in 2001 by the management of Shell South Africa in order to understand the possible impact of HIV/AIDS on Shell's markets in six countries of Southern Africa: Namibia, South Africa, Botswana, Lesotho, Swaziland and Mozambique. The principal conclusions are summarized here.

Horrendous, but Manageable Epidemic.

The HIV epidemic has spread widely among young adults in Southern Africa, which now has the highest infection rates in the world. These vary from 10-15% in Mozambique to nearly 40% of pregnant women in Botswana. We know that nearly everyone infected with HIV will eventually fall ill and die of AIDS, usually 7-10 years after the original infection. However this will happen little by little. In one model, 4% of the adult population will be ill or die of AIDS in 2008, even though the HIV prevalence ten years earlier, in 1998, was roughly 22%. This is because the annual death rate reflects the annual rate of new infections 7-10 years earlier, while the prevalence rate counts everyone who is HIV+ in a given year, regardless of when they were infected. These figures mean that the burden of disease in any one year will be manageable and – given the long incubation period – it is a burden for which we can prepare.

Projected Economic Impact of AIDS

We know that households with AIDS are hit hard, with disposable income and savings being affected, and new household types – grandparent households, orphan-headed households – appearing after parental death from AIDS. In **companies**, both the direct and indirect costs of AIDS are expected to rise, with some of the costs becoming visible now. The **macro-economic models** all project that GDP growth rates will be depressed 0.3 to 1.6 percentage points below non-AIDS growth rates due to reduced productivity and higher company costs, less disposable income, and greater government spending. Studies of **market impact** show that populations in 2020 will be only slightly larger than the population today and smaller and previously predicted.

Interviews in Shell – evidence and postulations about market impact

Interviews with Shell managers in 2001 found that there is **little current evidence** that AIDS is affecting Shell's markets. However, there is increased illness and absenteeism among the forecourt staff in Gauteng and KwaZulu Natal and other signs exist that the disease could become more serious, including a rise in funerals and death notices among young people. In the **retail** sector, Shell staff **postulated** that slower population growth, slower growth in personal income and the loss of disposable income would affect retail sales. In the **commercial** market sector, the dominant assumption was that AIDS would create higher employment costs for commercial clients who would then either mechanize production, squeeze suppliers such as Shell, or possibly go out of business. There was also a fear that illness among Shell staff would increase the risk of accidents, especially in refining and transport, which could then affect sales.

Diagrams showing 'who depends on whom' in Shell's markets found only **one clear hot spot** where the epidemic is currently affecting the business. This is the commercial road transport sector, where drivers have a higher than average rate of infection. Otherwise, Shell is integrated multitude of ways into the economies and societies of Southern Africa and its future markets will reflect the future economies and societies of the region. The study team also concluded that the future impact of HIV/AIDS could not be deterministically predicted, as a myriad of future decisions by individuals, businesses, NGO's and Government will all influence the way in which the future impact of the epidemic unfolds. This made it infeasible to calculate a clear impact of AIDS on Shell's markets and led to the decision that scenarios should be written.

Scenarios of the Future

There are **three strong driving forces** spreading HIV/AIDS. The first force is the *'Autonomy of Disease'*. HIV, like other diseases, has a life of its own. It is a living, evolving organism in a complex ecology that humans can barely control. The second force is the *'Jaiphur Paradigm'* that argues that the HIV epidemic spreads fastest when, as in Southern Africa, society is relatively wealthy, but has low social cohesion. The third driving force is the *'Tension between Two Worlds'* – African and European. This tension has created an unhealthy dialectic in which long distance migration, reduced social cohesion, and competing explanations for HIV/AIDS have made it hard to slow the spread of the disease.

Given these three strong driving forces and the high current prevalence of HIV, it is **inescapable**, that HIV will continue spreading for at least the next 5 years and that societies will face a rising death rate among young adults for most of the next 20 years. This will bring suffering to households, higher costs to businesses and slower economic growth in the region. However, it appears that these economic costs are bearable and the major risks are social and political, as no one knows how societies will respond as more people die of AIDS. This is the **major uncertainty**: will societies fracture fragile social contracts, especially in South Africa, by refusing to accept the demands of the disease? Or will people use AIDS and its challenges to build stronger foundations for the future? The three scenarios, written with South Africa in mind, present three different answers to this question.

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[1] Used with permission.

"New Schisms" Scenario

New Schisms is a world in which the Western capitalist system dominates, where success is measured in money and things. It begins as the South African government seeks to build a strong Western-style economy managed by capable African hands. In an early attempt to attract foreign investment, the government's policy on HIV and AIDS changes. The government tacitly accepts that HIV causes AIDS and grants limited rights to treatment. However, the main policy response is to reduce poverty through growth. When foreign investors fail to appear, policy shifts towards the development of a self-sufficient African market through investment in new regional roads. These roads help increase economic growth, but they also increase competition and help to spread HIV. As firms are driven out of business, unemployment does not fall as far as hoped. Furthermore, the benefits of the new regional economy are not well shared, so that while some people become wealthier, many remain poor. This inequality also encourages the spread of HIV/AIDS. As economic growth is emphasized, the legacies of African culture are pushed underground. The new campaigns to slow the spread of AIDS are based on the Western medical model and have little impact on many people at risk. As the public campaigns fail, leaders in KwaZulu Natal ask for more government resources to respond to AIDS. Their requests are refused. The IFP breaks with central government and calls for a return to traditional values???????

Little by little, the different cultures in society stop engaging with each other. New Schisms are created as HIV prevalence and deaths from AIDS continue to climb, slowing the economy down in the second decade of the scenario period. New Schisms is an unstable world.

"Silence is Deadly" Scenario

This scenario begins with a global economic slowdown and Government beset by demands for solutions to a multitude of problems. As the value of the South African Rand falls, inflation and unemployment rise. The rising death rate becomes more evident but the issues around AIDS policies are simply too difficult for Government to resolve. Increasingly, the language of AIDS reflects a sense of exclusion from the benefits of a new South Africa. "What did the struggle achieve?" ask many people. There is a growing division in society as the wealthy retreat behind razor-wired walls or leave the country. Despite the noise, few are ready to accept the disease. There is continued denial and blame on all sides. In communities everywhere AIDS is still not given a name, even when young people are dying of the disease. As AIDS hits families, children are withdrawn from school. However even those children who manage to get to school are getting a lower quality of education because teachers are falling ill and leaving their classrooms for long periods. The lack of education and employment fuels the epidemic further. As the general economic situation worsens, the quality of government declines. With little employment available, there is an increase in government patronage jobs, causing a further decline in the quality of government service. Worse, with the lack of any clear policy on the treatment of AIDS, there is a growing black market in anti-retrovirals that create drug-resistant HIV. With no jobs, no money, and the threat of death all around, many people are angry at the failure of the ideals that once ended apartheid. Feeling both tricked and bewildered, they treat the messages about AIDS as just another hoax. This is a story of failed ideals and the violent incomprehension of separate lives. On all sides, one hears the question: "Why should we even try to live together?" but there is no clear reply.

"Communities of Survival" Scenario

Communities of Survival begins slowly as more and more people speak openly about the AIDS crisis. They ask themselves and each other: 'Where did we go wrong?" In late 2003, a delegation from KwaZulu Natal approaches Government, asking for a change of policy. In response, the government devolves responsibility for HIV/AIDS, sub-contracting to local and provincial bodies both inside and outside government. This encourages new partnerships, the skills for which build slowly over the next 5-10 years. Independently, the business sector also begins to respond, finding ways to educate and protect their workforces, including the use of low-cost treatment with anti-retrovirals. As managers give their attention to AIDS, they find themselves caught in a dilemma: there is a clear social crisis, but foreign and local shareholders complain about poor earnings, assuming that disease is a government job. Public relations campaigns intensify in financial markets. The business policy of treatment, however, has an unexpected benefit: it encourages many HIV-positive people to declare their status. AIDS gradually becomes a normal disease and behaviour begins to change. On another front, Western-trained doctors and traditional healers work more closely together. By 2006, new procedures are developed to admit qualified sangomas and inyangas into Medical Aid schemes. The public language of intervention broadens to include African beliefs about the causes of disease. HIV prevalence starts to fall in 2008 but deaths continue to rise. Women with HIV worry above all about the future of their children and personal requests for help multiply in all directions – to family, friends, neighbours, bosses and organizations located nearby. Many respond, with new organizations arising to meet the new need. By the end of the scenario period, government is smaller, but more effective. The real achievement has been the growing social engagement and trust in society as all cultures recognize they are fated to live together and can do so successfully.

Recommendations

In all three scenarios, Shell needs to monitor, minimize and manage the epidemic in its own operations. Monitoring includes a profile of the workforce and its health, as well as monitoring the market for any signs of an increased impact from AIDS. Minimising means working to limit the spread of HIV among staff, partners and customers. Managing includes having clear policies on treatment, retirement and other issues related to managing the effect of ill health in the workforce and working to maintain morale among those who are not ill. All of these efforts need to engage not just Shell staff, but also those who are linked to the company as franchises or contractors or suppliers. In taking these actions, it is important to create the sense that Shell is a community that cares, that it is a company made up of people who look after each other and the world around them. AIDS may be a medical issue, but social interventions are likely to be most effective. Many of these recommendations are already being followed.

Shell also has a responsibility in the broader community. This is where Shell as a responsible corporate citizen has an important role to play by, for example, supporting efforts to maintain or improve access to education throughout the epidemic, as well as encouraging an industry-wide responses to the disease, something already begun with SAPIA. Shell should also encourage staff to respond personally and learn to benefit from what staff gain by engaging with others outside of Shell.

Given the gap between the African traditions and Western concepts of disease, it is also recommended that Shell hire a company sangoma to work with staff internally and in the wider community. Finally, the study team believes that the scenario work should be made public, possibly in a road show, in order to encourage a wider debate on managing HIV/AIDS in society. There is a clear consensus that HIV/AIDS will have business implications. Some are already apparent, others will become more important in the years ahead. All need to be debated. For example, as growth will be slower in all

scenarios, how will Shell cope with a decade of lower growth? How can Shell manage lower workforce productivity? What can and should Shell do to manage the shortage of big vehicle operators in the region? These are a few of the issues that are likely to arise.

Dilemmas

None of these recommendations are easy to follow and all draw the company further into two serious dilemmas. First, it is one thing to say that Shell is a community that cares, but where is the boundary of Shell's community? This needs to be thought through carefully. Second, and more profoundly, surviving the AIDS epidemic and helping the societies of Southern Africa become stronger through this crisis will raise the costs of doing business in the region and will inevitably affect returns. It is clearly a 'right thing' to do. But how can it be squared with the stock market's expectations for reliable quarterly returns? In managing these two dilemmas, imagination, innovation and care will be required.

APPENDIX 3; HAC/EHA/ WORK PLAN FOR 2004-2006

GOAL   To develop WHO capacity to contribute to and improve national and international preparation for and responses to crises by working with UN and other partners, National Governments and civil society to assess, map and monitor vulnerability, to identify health priorities and to support prioritized health action by all stakeholders.

OBJECTIVES	STRATEGY	ACTIVITIES	INDICATORS	DELIVERY DATE	RESOURCES REQUIRED	BUDGET US$	STAKEHOLDERS
To strengthen the capacity of WHO at regional, inter-country and country levels to be a reliable and effective partner in supporting communities and health stakeholders as they prepare for, and response to, the health aspects of acute and long term crises so as to minimize suffering and death and open the way to recovery of sustainable health livelihoods	Increase presence and capacity of WHO at country level	Develop TOR for HAC FP	TOR agreed	6/1/2004	Salary, travel, operational expenses, office equipment, etc 75,000/country/year	1,350,000	MOH and related GOV, NGOs, UN, Donors etc.
		Recruit WCO HAC FP (Full Time) with appropriate aptitude	Staff recruited according TOR	9/1/2004			
		Recruit and second staff to MoH if required	Staff recruited according TOR	9/1/2004			
		Organize training for EPR focal persons	Number EPR focal persons trained	June 04, 05, 06	At least one training per year: - expertise	90,000	HQ/AFRO/ICT/WCO
		Training in VA, scenario planning including CAP and disaster management	Response plans, CAPS developed	9/12004	Financial, 20,000x2/country	240,000	HQ/AFRO/ICT/WCO
	Develop WHO presence at sub regional level	Maintain or recruit ICT Coord, Epidem, Nutrition, Data Manager, RIACSO team leader, Pub Hlth Specialist, Information Manager,	Number of sub regional staff in place	4/1/2004	Salary, travel, operational expenses, office equipment, etc 1 million US$ per year 3 years	3,000,000	Donors, WHO/HQ, WHO/AFRO, ICT, WCO
		Provide technical input to and participation in joint UN sub-regional initiatives.	Number missions				
		Provide technical advice and support to country offices	Number of regular country visit number request attended				
	Manage information, contingency plan, training on Health in Crises and document experience	Conduct regular health impact assessments	Health Impact assessment conducted at least once a year	06/2004, 2005, 2006	Human, material, field expense, 100,000 per year/per country	1,440,000	AFRO, ICT, WCO, MOH, UN, NGOs and relevant partners
		Disseminate information through meetings and guidelines and reports	Guidelines, protocols, report produce and disseminated	08/04, 08/05, 08/06	Financial support for printing, distribution and meetings, 10,000/country/year	180,000	HQ/AFRO/ICT/WCO

OBJECTIVES	STRATEGY	ACTIVITIES	INDICATORS	DELIVERY DATE	RESOURCES REQUIRED	BUDGET US$	STAKEHOLDERS
To strengthen the capacity of WHO at regional, inter-country and country levels to be a reliable and effective partner in supporting communities and health stakeholders as they prepare for, and response to, the health aspects of acute and long term crises so as to minimize suffering and death and open the way to recovery of sustainable health livelihoods	Manage information, contingency plan, training on Health in Crises and document experience	Conduct vulnerability assessments and disseminate reports	Reports produced and disseminated	Over 3 years	Financial, 20,000/year/country	120,000	
		Financial support to district training of trainers in HAC	Number of people trained	Jun-04	Financial 60,000/country/year	360,000	ICT/WCO
	Coordination of HAC with partners and WHO departments	Provision of guidelines and tools on HAC	Number of guidelines produced and approved by National Ministries stakeholders familiar	4/1/2004	Material and production cost, 20,000/year	60,000	HQ/AFRO/ICT/WCO
		Organize coordination meetings, minutes and reports prepared and distributed	Quarterly meetings arranged	over 3 years	Material and production cost 30,000/country	90,000	ICT/WCO
		Sensitization meeting for policy, decision makers, MoH, WHO and partners in HAC	Number participating	Ongoing	Financial 20,000/country/year	120,000	ICT/WCO
		Organize review meeting with GOV and partners	mid term review conducted	12/42004	Financial 15,000/country/year	90,000	WCO/ICT
	Emergency stock in place	Restock regional emergency stores	Emergency stock for cholera and EHK	Ongoing	Financial 00,000/per year	300,000	HQ/AFRO/ICT/WCO

OBJECTIVES	STRATEGY	ACTIVITIES	INDICATORS	DELIVERY DATE	RESOURCES REQUIRED	BUDGET US$	STAKEHOLDERS
To reduce vulnerability associated with crisis in Hot Spots	To contribute to the 3x5 initiative to make ART more widely available in selected hot spots	Identify hot spots and implementing partners	District/ hot spots identified and project implemented	12/1/2004	WCO project coordinator 100,000/country	600,000	3 by 5 task force MOH, WCO, ICT RPA, implementing partners, affected communities.
		Train HCW in management of HIV related conditions incl ART	Training completed	4/1/2005	Manuals, DSA travel, etc	100,000	
		Support development of facilities and systems for delivery of ARV	Facilities and systems developed	4/1/2005	Supply and equipment	100,000	
		Monitor and evaluate delivery of ARV base Health Care	Priority groups provided with ART - 50% of all	6/1/2005	ARV drugs		To be supplied by 3 by 5 or from other sources e.g. GFATM with in countries
			100% of above	6/1/2006	ARV drugs		
	Institutional and human capacity development in nutrition in crisis	Establish /strengthen nutrition surveillance system	Number of countries strengthened surveillance system	Over three years	Consultants, training expenses, logistics support 30,000/country/activity	180,000	AFRO, ICT, WCO, MOH, UN, NGOs and relevant partners
		Training on the management of severe malnutrition for the health professional	Training severe malnutrition conducted	Over three years		180,000	
		Training for the community health workers on identification, management and referrals of nutritional deficiency disorders	Training for community health workers conducted	Over three years		180,000	
To improve the surge capacity of region and sub region to respond to acute crisis	Teams to be deployed in countries with acute crisis	3 teams of 2 members ready to be deployed to crisis hit countries for up to 4 weeks - team will be formed from HQ, AFRO, ICT	Number of teams deployed	Over three years	Public health specialist, epidemiologist, nutritionist or environmental experts:- 24/man/month/year consultancy fee, DSA	150,000	HQ/AFRO/ICT
			TOTAL			8,830,000	

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