Southern African Health Challenges Intensify.
13 September 2004

In August 2002 SADC Health Ministers issued a “Call to Action” in response to the humanitarian crisis in southern Africa triggered by severe drought that had engulfed the entire sub-region. The focus of attention at the time was to avert serious food shortages. It was also generally agreed that this was not just a food crisis, but a complex crisis with major health and other social dimensions.

The ministers noted that the drought situation was superimposed on an already grave health situation. They committed themselves to ensuring that health systems function effectively, to improving access to basic health services and increasing the availability of clean water. They further pledged to strengthen monitoring of the capacity of health systems in detecting malnutrition, and to promote other national initiatives aimed at supporting vulnerable populations. Two years later, however, the humanitarian situation in southern Africa continues with a vengeance, resulting mainly from vicious and destructive spirals of sharply increasing HIV/AIDS morbidity and mortality, health systems that are increasingly unable to meet demand, disintegrating communities and deepening poverty.

To get a better understanding of the health aspects of the crisis, WHO supported Ministries of Health in the six worst, affected countries to conduct Health Impact Assessments. Four of the assessments were carried out in the period between July and December 2003. The findings were presented at a meeting held in Johannesburg from 23-25 August 2004. Participants, including the WR for Swaziland, officers from ministries of health, and technical officers responsible for Emergency and Humanitarian Action from WHO country offices, the sub-regional inter-country team (ICT), RIACSO, AFRO and WHO/HQ, also discussed the way forward for addressing ongoing and emerging challenges and for institutionalisation of future assessments.

Effects of HIV Pandemic.
The HIV pandemic is having a major and exponentially increasing effect on vulnerability; individuals, and families are infected and affected, with the resultant ill health and death reducing labour availability, increasing health care costs, creating orphans and leaving whole communities extremely vulnerable to the impact of whatever additional shock. Within the health sector the increasing disease burden, is placing enormous strain on public health services, and this is compounded by indicated by staff absenteeism and high vacancy rates.
Information gathered from the assessment, together with data from other sources including the Demographic and Health Surveys and the VAC assessments, reveals a picture of high crude, under 5 and infant mortality; in some areas the levels approach or exceed those accepted internationally as indicating a crisis requiring an immediate response. Age specific patterns clearly indicate the effects of the HIV pandemic in the sub-region (see figure); in a “normal” situation one would expect the mortality curve to remain close to zero throughout adolescence and into middle adulthood (15 – 50) and only then to begin to rise as age starts to take its toll. The rise in early adulthood is clearly indicative of a major deviation from this and is almost certainly the result of HIV.

The prevalence of orphans was high at between 15 and 20%. Acute and chronic morbidity levels were also high, and – worryingly - access to and use of health services were low. The main barrier to use of services was financial, highlighting the worsening poverty situation among the populace. In spite of the substantial efforts and achievements of governments and the international community to avert famine over the last two years indicators of chronic malnutrition were still high.

In general health systems were dysfunctional; their institutional and structural capacity is clearly inadequate to cope with the burden being imposed on them. Coverage of several crucial services has been reduced and as evidenced by the performance of maternal and child health services, the quality of remaining services is sub-optimal. Essential infrastructure is lacking, key equipment and support services are either missing, inadequate or not functioning, medical supplies are insufficient and monitoring and surveillance systems are close to failure. The capacity of skilled health staff to deal with the increasing health problems remain very low across all the affected countries; and where information is available, morbidity and mortality amongst staff is high. Supervision of field staff is poor or absent. Data on staff morbidity and mortality is generally lacking, but where available it is startling; in two countries annual mortality amongst staff was 2.5% and 3.8%!

It is clear from the findings of the analysis, and this is corroborated by the recent report of the UN Secretary General’s Special Envoy for Humanitarian Needs in southern Africa, Mr. James Morris, that the crisis afflicting the sub-region is far from over. Health systems are not in a good position to deal with the catastrophe; massive resources and urgent action are required within the sector to deal with the situation, which is increasingly recognized as health centred.

It is essential therefore that the crisis does not disappear from the public eye and off the political agenda. WHO is taking steps to ensure that this does not happen; it is ensuring that the findings are brought to the attention of Ministers of Health. UN, donor and other partners will be briefed and subsequently WCOs will assist to identify priorities, develop strategies and to coordinate field interventions to address this ongoing, insidious crisis.

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For further information, please contact:

Division of Healthy Environments and Sustainable Development
Emergency Humanitarian Action Unit
World Health Organization - Regional Office for Africa
P.O. Box 6 Brazzaville, Congo.
E-mail: chellouchey@afro.who.int

EHA Inter Country Team
World Health Organization Country Office,
Parirenyatwa Hospital
Harare, Zimbabwe
Mobile: +263 91 279258 ;
E-mail: mulugetag@whoafr.org