

# A 4-D Model for Emergency Relief: Toward Understanding the Systemic Implications of HIV/AIDS in Sub-Saharan Africa & the Challenges of Aid Delivery

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The challenge of HIV/AIDS in Sub-Saharan Africa must be weighed against the backdrop of systemic tensions exacerbated by the current crisis. Viewed within the confines of a matrix whereby the state begins to fail thus pushing the system from the *top-down*, epidemics such as HIV/AIDS applying an opposing force from the *bottom-up*, and non-state actors pushing *laterally* at the core of the system, today's relief agency's only recourse is to also push back *laterally* against this core. They must do so in order to affect systemic equilibrium for their intended recipients of aid. Seen in this conditional matrix housing four opposing systemic forces, relief agencies now face dramatic system challenges calling into question the very nature of their mission and roles in humanitarian intervention. Against this four-dimensional matrix, the author explores the specific challenges of getting aid delivery to those afflicted with HIV/AIDS and questions its place within the realm of complex emergencies.

## **Introduction**

When analyzing the international relations system, one often thinks of systemic catalysts fueling political conflict and crisis from the *top-down*. From this lens, as a state begins to fail and its ability to govern declines, chaos ensues, with often dire implications for its population. Many times, such consequences manifest themselves in the form of civil war, criminal activity, population displacement, disruption of livelihoods, and food shortages.

Today, however, we see that the crisis landscape is changing dramatically. While we cannot completely discount traditional analytical lenses that look at state implosion as a catalyst for crisis, humanitarian relief agencies are increasingly experiencing the

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opposite directional relationship on the ground. More and more *bottom-up* crises that begin with health epidemics and thus, human insecurity, are emerging as a threat to the state itself.

Exacerbating the problem even further is the rise of non-state actors and their potential disruption of political access and aid denial to populations in crisis. Acting in a sub-state but hyper-political context, such players have the ability to dramatically disrupt any intervention by *laterally* forcing the same system already facing *top-down, bottom-up* tension to accommodate their political will. For their part, humanitarian aid agencies now find themselves also *laterally* pushing back against these very sub-state forces in their attempt to provide aid to those in need – all of which is

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taking place in the same *top-down, bottom-up, lateral* matrix of systemic tensions at play. As a result, the fundamental nature of not only conflict, but intervention itself, is changing dramatically.

also the role that humanitarian agencies play as aid deliverers, conflict mitigators, and long-term development facilitators for populations in crisis.

Nowhere are these tensions and challenges more apparent than in the case of HIV/AIDS in Sub-Saharan Africa. Through this unique crisis, what the humanitarian community is in effect witnessing is a shift not only in fundamental systemic assumptions of international security theory, but

The purpose of this paper, then, is to address the changing role of humanitarian intervention not only within the context of a changing crisis system in general, but also with respect to the level of complexity that HIV/AIDS presents in particular. It will do so by addressing two fundamental questions:

- What are the systemic implications that both states and humanitarian relief agencies face with respect to HIV/AIDS?
- What are the specific challenges of getting access and aid delivery to communities affected by HIV/AIDS?

Ultimately, I will argue that the issue of humanitarian relief with respect to HIV/AIDS is replete with systemic implications requiring a modified framework of analysis and intervention. By systemic implications, I refer to the structural conditions which include the politics, economics, social, cultural, and security aspects of a group of people that provides the basis for a unified, collective and functioning identity. Such structural conditions are the dynamic forces that hold nation states together. Moreover, systemic implications, to include any reference to ‘system’ or ‘system(ic) impact,’ refer to the interplay of these structural conditions and, in some cases, their complete or partial collapse, and the potential repercussions of these processes at a local, state, regional, and international level. Underpinning this ‘system’ reference is chaos theory which holds that systems, no matter how complex and non-linear they may appear, rely on an underlying order; and that even the smallest of events can trigger complex, and at times, massive reactions. To explore the proposed questions, however, we must first understand the gravity of the epidemic.

### **Framing the HIV/AIDS Epidemic: Understanding the Magnitude**

In 2006 alone, an estimated 2.8 million people in Sub-Saharan Africa contracted HIV.<sup>1</sup> In this same period, over 2.1 million adults and children died of AIDS.<sup>2</sup> Despite the fact that this region only accounts for 10 percent of the world's population, it "is home to more than 63% of all people living with HIV, i.e. 24.7 million."<sup>3</sup> With the average death age from AIDS being as low as 37 years in only the last four years,<sup>4</sup> those between the ages of 15 and 49 are particularly vulnerable to infection. As of 2005, over 4.6 percent of all young women between the ages of 15 to 24 were living with HIV. For the same sampling of men, the figure stood at 1.7 percent.<sup>5</sup>

While declines in national adult HIV appear to be underway in Kenya, Uganda and Zimbabwe, HIV prevalence levels throughout Southern Africa remain exceptionally high.<sup>6</sup> Within this region, women remain disproportionately affected by HIV. East Africa continues to provide the most hopeful indication that a reversal of the AIDS epidemic can be achieved.<sup>7</sup> The steep countrywide drop in HIV prevalence among pregnant women in Uganda since the mid-1990s is now being experienced in Kenya.<sup>8</sup>

Progress in expanding treatment and care provision in Sub-Saharan Africa in the past year has been uneven. At least one third of the people in need of antiretroviral therapy are receiving it in Botswana and Uganda. This is in stark contrast to Cameroon, Côte d'Ivoire, Kenya, Malawi and Zambia where only between 10 and 20 percent of the people requiring antiretroviral drugs were receiving them as of mid-2005.<sup>9</sup>

For most of the region, however, there is extensive unmet need. In South Africa alone, nearly 85 percent of those needing antiretroviral drugs had not yet received them as of mid 2005, representing over 900,000 AIDS patients.<sup>10</sup> The same situation applied to over 90 percent of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.<sup>11</sup>

### **Understanding the Epidemic's 'S' Curves: A Crisis in the Making?**

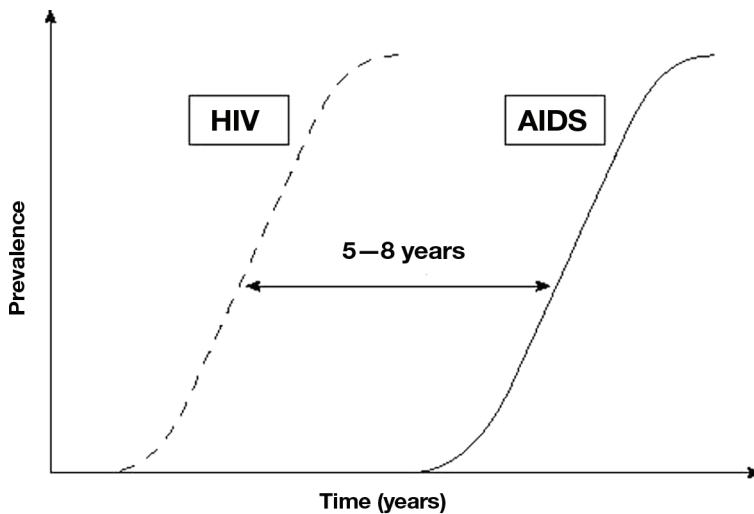
HIV/AIDS is unique in that the shape of the epidemic follows an 'S' curve. At the onset, the number of HIV infected people climbs slowly until a critical mass is infected at which time a 'tipping point' is reached. At this point, the number of new infections accelerates and many of those who are susceptible contract the disease. In the final phase, the curve flattens out and then begins to turn downward as people either regain their health or the number of deaths, as a result of the disease, begins to outnumber new infections.<sup>12</sup>

What sets this epidemic apart from others, however, is the presence of two 'S' curves. As shown in Figure 1.0, one curve represents the asymptomatic HIV, the other 'full-blown' AIDS. What is striking about the illustration is that the HIV curve precedes the AIDS curve by about five to eight years. This long incubation period is what makes HIV/AIDS so deadly. With most life-threatening infectious diseases such

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as Ebola fever or cholera, the time sequence for visible symptoms may be as little as days or weeks. Such signs essentially immobilize sufferers. This, in turn, has the effect of restricting the spread of disease. Health authorities can then take appropriate measures.<sup>13</sup> In the case of HIV/AIDS, there is no such immobilizer.

**Figure 1.0: The two pandemic curves**



**Source: Barnett and Whiteside 2002<sup>14</sup>**

This epidemic, therefore, bears unique characteristics, one of which is specific to Sub-Saharan Africa. First, the ‘silent’ incubation period for HIV alone allows the virus to spread unabatedly. Second, this period facilitates transmission as HIV transmitters are often unaware they are carrying the disease.<sup>15</sup> Third, that HIV/AIDS is transmitted through intercourse invokes intimate aspects of people’s lives. “It attaches notions of propriety and retribution to the disease that often serve to keep HIV/AIDS strictly within the realm of the private, facilitating secrecy and further ignorance and denial.”<sup>16</sup> Fourth, such secrecy also helps to perpetuate the stigma often attached to AIDS. This sequence facilitates even more secrecy. And fifth, unlike the developed world where HIV/AIDS has predominantly afflicted specific population groups (i.e., male homosexuals and intravenous drug users), in Sub-Saharan Africa the epidemic is spread mostly through heterosexual activity. These characteristics provide for a perpetual and stealth-like crisis with tremendous short and long-term implications.

### **Isolating the Household: The Systemic Implications of HIV/AIDS**

The systemic crisis that HIV/AIDS represents goes to the heart of livelihood theory. When one analyzes the livelihood impact of the current epidemic, it becomes apparent that the security risk imposed has the potential to be on par with that of war and conflict. An examination of how livelihoods are impacted by the epidemic and the resulting systemic repercussions becomes critical to understanding the tensions this *bottom-up* epidemic places on the state and system as a whole.

To begin however, we must briefly touch on the tenets of livelihood theory in order to understand why it is so relevant in the case of HIV/AIDS. At our most fundamental level, people instinctively create complex systems for managing risk, and consequently, emergencies. A household's goal, for example, of food security goes way beyond its consumption. Rather, it begins to prioritize the protection of its productive assets over its non-productive ones. This trade-off occurs as people have both a physical and psychological need to protect their livelihoods for their household's well-being. Crises, therefore, not only present vulnerability for the household in terms of food security, but also directly challenge its ability to cope with disasters.

In this particular case, it is absolutely critical to understand the economics of livelihood theory at its core unit of analysis, the household. To understand where the household rests with respect to the system, one has to understand that in a period in which economic sectors are in distress, opportunities do not increase. In fact, they decrease significantly and more so for a family where at least one of the adults is ill. This is significant because "UNAIDS estimates that income in poor households with an HIV-positive member may decline by as much as 40-60 percent."<sup>17</sup> In a region where HIV/AIDS is the primary cause of death for 25-49 year olds, the livelihood consequences are particularly catastrophic as this age group is typically one that is caring for both the household's young and its elderly. People within this age range are also the most productive members of society. Taken together, once terminal illness sets in, a downward spiral ensues with multidimensional consequences.

Exacerbating the issue is the fact that in many parts of Africa where subsistence agriculture is paramount to the household, the illness of a critical member reduces labor, and hence diverts resources away from where they are desperately needed. This occurs not only when a once productive family member falls ill and cannot tend the fields, but also when other productive family members must leave their work to care for that person. In addition to the loss of the household's critical productive asset(s), households also have manage the added expenses of medication and healthcare for the ailing member. Often, this means drawing from savings, selling assets such as livestock or land, and taking up additional employment or loans to cover costs. This can also lead to increased psychological strain on the household. In addition to the basic coping strategies individuals fall back on as a means of addressing shocks to their livelihood systems, one must also consider the psychological ramifications of these shocks.<sup>18</sup>

Another harsh reality may exist in situations where the caregiver, perhaps a spouse, might also be suffering from asymptomatic HIV or AIDS. In such circumstances, the provision of care can be especially taxing on the caregiver. More importantly, "[as] families have less to spend and produce less food, the quality and

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quantity of the food consumed by household members declines.”<sup>19</sup> This is particularly true when family members, out of good intent, give better quality food to the ailing relative.

Frequently, such caretaking, along with significant financial implications, has repercussions on children, irrespective of whether they are infected or not. They are often withdrawn from school in order to assist in caretaking or other household tasks. Some children may also be forced to work in order to compensate for lost wages. As a result, an already struggling household can experience a steep decline in its living standards. According to UNDP, “61 percent of Zambian households that have lost a member to HIV/AIDS moved to cheaper housing, 39 percent lost their access to piped water, while 21 percent of the girl and 17 percent of boy children dropped out of school.”<sup>20</sup>

In some cases, death itself, or impending death may even lead to the fragmentation of the family unit. When children lose one or both of their parents, or if the family is simply not able to support itself financially, the remaining members may be forced to go separate ways. Orphans may even find themselves bearing the responsibility of raising their even younger siblings. For those forced into such a situation, it may mean dropping out of school in order to search for work to support the household of which they are now in charge. What we have in this case is the near-total collapse of the household. Sadly, “this lack of schooling, often combined with a lack of nutrition, may make it particularly difficult for orphans to escape poverty.”<sup>21</sup>

Within the meta-social context, this cycle of household disintegration also presents significant implications at the regional and state level. The United States Agency for International Development (USAID) estimates that “[b]y 2010 Southern Africa will contain 5.5 million maternal or double orphans (16 percent of all children under the age of 15 years), of which 87 percent will be orphaned because of AIDS.”<sup>22</sup> This is significant because it tears against the fabric of Africa’s age-old social safety net in that extended family networks will simply be unable to cope with the soaring number of AIDS orphans. It also impacts the state, as children left to fend for themselves become more vulnerable to crime.<sup>23</sup>

While HIV/AIDS acts as a deterioration catalyst for the household, the implications it bares are much further reaching. This is precisely why Peter Piot, Executive Director of the Joint United Nations Program on HIV/AIDS (UNAIDS) recently stated, “[b]y overwhelming Africa’s health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability.”<sup>24</sup> Taking into account the statistical projections of this expanding epidemic and its impact on labor availability, overall agricultural practice, local economies as a whole and the dire social implications being borne, it becomes clear that the very threat to livelihoods stemming from the household, has the potential to dramatically impact communities, states, and even regions as a whole.

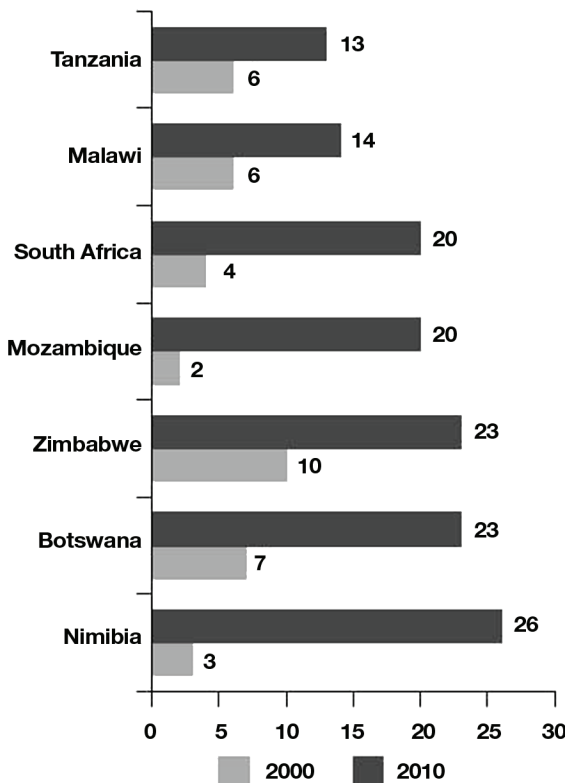
### **Widening the Circle: Understanding the Full Impact Beyond the Household**

Beyond the micro-level household looms the impact of livelihood deterioration at the macro-level. Nowhere is such negative impact more profound than in the area of agro-economics. As agriculture for much of Africa provides a living for well over 80

percent of the population, any decrease in agricultural labor bares significant consequences in productivity.<sup>25</sup> As a result, “[p]atterns of cropping shift [systemically] from cash crops to subsistence farming, reducing household income and forcing families to sell their assets to survive.”<sup>26</sup> What this means essentially is that the agricultural system as a whole is particularly sensitive to labor pool decreases. It also means that at the system level, the impact of livelihoods theory is significant.

Emphasizing this point, the UN’s Food and Agricultural Organization’s Committee on World Food Security notes that, “in the 27 most HIV/AIDS-affected countries in Africa, seven million agricultural workers died as a result of AIDS between 1985 and 2000.”<sup>27</sup> The same report also forecasts 16 million more deaths by 2020. With labor pools decidedly being impacted by this epidemic, the vulnerability of the system becomes increasingly apparent (See Figure 2). Not only are the region’s labor pools being dramatically impacted in terms of numbers, but productivity issues also arise as infected populations transition from HIV to AIDS. All of this, however, is looking at agricultural output as though it were in a vacuum. To realistically appraise the situation, one would have to take into account the timing of labor shortage (i.e., period of harvest matters) and the fact that we are not even taking into consideration climatic periods of drought or heavy rains where crop yields are low from the onset. Were such to occur, the system, which is already vulnerable due to a decrease in labor power, might be pushed to the brink of collapse. HIV/AIDS, therefore, once again has an innate ability to stress the system from the *bottom-up*.

**Figure 2: Proportion (%) of agricultural labor force lost due to HIV/AIDS in selected SADC countries, 2000 and 2010<sup>28</sup>**





When looking at the state within the context of the system as a whole, the situation becomes even more precarious when one assesses the impact of HIV/AIDS on the economy. Already we see that as a result of HIV/AIDS, investors are demanding higher returns in the order of over 25 percent in some areas to justify their potential investment risk into Sub-Saharan Africa.<sup>29</sup> That HIV/AIDS is detrimentally affecting the state as a whole is also evident in that, “it is projected that around 2010, South Africa, which generates about 40 percent of Sub-Saharan Africa’s economic output, is likely to have a real gross domestic product (GDP) 17 percent lower than what it would have been without AIDS.”<sup>30</sup>

What should also serve as a warning indicator of the state’s vulnerability as a result of the HIV/AIDS epidemic is the threat it poses to the state’s major sectors

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of which many of the economies of the Southern African Developing Countries (SADC) depend. Here, the mining sector plays a critical role not only in terms of the sheer numbers employed, but by the foreign exchange generated as a result of mineral exports.<sup>31</sup> In this sector alone, “the South African Union of Mineworkers estimates that their members could see between 12,000-14,000 AIDS-related deaths per year by 2010.”<sup>32</sup> The implication is simply that the epidemic has and will have a tremendous negative impact on the export earnings for the region. Because the epidemic is beyond the control of the states in question, it has to be looked at as a systemic catalyst for crisis.

The question is: how will the state respond if it internally cannot sustain its own needs due to its labor force being dramatically stricken while at the same time it cannot fully capitalize from its own major export sectors because of the same problem? Clearly, on this matter, the state is not in complete control. And because it is not in control, many fear that “the negative synergy between infectious disease (in particular HIV/AIDS), population dynamics, weak government structures, and long-standing grievances in segments of the population [will create] a downward spiral between infectious disease and state capacity to respond to it.”<sup>33</sup> Whether such impacted states will spiral out of control is unclear. What is clear, however, is the incredible strain the international system is bearing given the inherent tensions from the state level, and the *bottom-up* nature of HIV/AIDS that is clearly stressing an already precarious relationship. What remains now is to explore the simultaneous *lateral* tensions at odds within this same matrix. To do this, we now turn to the complexities and tension that the humanitarian aid community faces in delivering aid.

### **Lateral Tensions: The Relief Agency’s Dilemma**

The challenge for humanitarian relief agencies is to enter this complex emergency, replete with tension from all directions, in order to assist those most in need. This is particularly true with respect to food aid delivery, which has shown to be an integral part of staving off the rate of HIV/AIDS transmission in the first place.



This vicious cycle between HIV/AIDS and malnutrition has been clearly documented.<sup>34</sup> HIV infection is accelerated with the cycle of inadequate nutritional intake. This, in turn, leads to weakened immune systems and disease. As such weakening occurs, the progression of HIV/AIDS infection increases significantly. Recent studies suggest that with adequate nutritional intake, the chance of HIV infection might even be reduced; this is to say “that the onset of disease and death might be delayed where HIV-positive individuals are well-nourished; and that diets rich in protein, energy and vitamins might reduce the risks of vertical transmission from mother to child.”<sup>35</sup> In fact, micronutrients have been shown to be particularly beneficial to strengthening immune systems. While more research is needed in the area of correlative impact of malnutrition and HIV/AIDS, it is clear that adequate nutrition which includes micronutrients improves an individual’s immune system substantially. At the very least, this can delay the onset of full blown AIDS which gets to the heart of this analysis as it is in this condition that the system as a whole experiences the most shock. But what happens when local forces prevent humanitarian aid agencies from providing that nutrition? Such is often the case when conflict exists.

Increasingly, war is seen as a catalyst, if not an instrument, for the spread of HIV/AIDS. No one disputes that conflict-related displacements aggravate already fragile systems. Such disruption invariably leads to increased poverty, dependency and powerlessness.<sup>36</sup> This, in turn, “can increase the likelihood of sexual coercion or bartering, sexual violence and consensual unprotected and unsafe sex.”<sup>37</sup> In an already highly susceptible situation, such crises can also be exacerbated by “the interaction of military and civilian populations, whether through commercial sex, or in rape as a weapon of war; and in the extreme vulnerability of displaced and refugee populations to HIV infection.”<sup>38</sup> Understanding this pattern of transmission, displacement and interaction is critical to gaining a full grasp of the challenges relief agencies face in getting aid to the appropriate target. It is important to remember that this same interaction is not limited to official military representatives. It also holds true for the scores of armed and violent non-state actors that may be fueling the conflict itself. These are some of the reasons why refugee populations are particularly vulnerable.

Refugee populations pose one of the biggest challenges for humanitarian relief workers in the context of HIV/AIDS. Single women and unaccompanied children within these populations frequently become victims of sexual coercion and or rape. This is especially true during the early stages of conflict. Frequently, as these populations are in process of relocating, they find themselves urgently needing basic necessities (i.e., food or medicine for their families). The exchange of sex for such basic needs or money can become commonplace thus increasing the potential for HIV transmission. In fact, “it has been shown that women, for example, are six times more likely to contract HIV in a refugee camp than the general outside population.”<sup>39</sup>

In this sense, women are particularly vulnerable in such conditions, not only as a result of conflict, but the HIV/AIDS epidemic as well. In Sub-Saharan Africa,

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women make up the majority of those living with HIV/AIDS. In fact, they are infected with the virus anywhere from 6-10 years younger than men. Studies suggest that women are even more biologically susceptible to contracting the virus than men through sexual encounter.

Even when looking at the social structures of Sub-Saharan Africa, the propensity for subjugation to men in many cultures facilitates epidemic transfer to women. As Paul Harvey of the Humanitarian Policy Group argues, “The low social status of women in the developing world magnifies their vulnerability to infection and constrains their ability to deal with its impact.”<sup>40</sup> Further, the burden of such exposure to the epidemic is intensified given the role of women in their households. As the main producers of food and caretakers for the sick and children, when women become sick, further implosion occurs on a micro-level. Extrapolating this gender-specific vulnerability to already insecure refugee populations, one gains a better understanding of the level of complexity and challenge that relief agencies face daily with respect to *lateral* tensions imposed on them; the biggest of which is often the question of, “how to get aid to those most in need?”

### **Getting Relief to Its Intended Target: New System Challenges & Issues**

Part of understanding the complexity of aid delivery in light of the tension matrix presented in this paper also involves understanding the unconventional factors relief agencies face on the ground. As the nature of the system is changing dramatically, aid agencies find themselves increasingly beholden to factors often beyond their intended and chartered responsibilities. As suggested at the onset of this paper, aid agencies now find themselves acting in the capacity of conflict mitigators and long-term development facilitators. As it is the total system that is facing this particular crisis, we will now address the challenges presented to relief agencies in general, followed by that of HIV/AIDS, in particular.

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Certainly, every society has some semblance of an enabling agent system to facilitate general aid distribution. However, it is often the case that armed non-state actors – responding to a lack of governance or political, social or economic injustice – will hinder the delivery process in order to advance their own power, prestige and interests. In such conflict settings, social control of the population becomes the strategic objective of such actors. What this means to humanitarian relief agencies is that such non-state actors will, in many cases, seek to disrupt access and delivery of aid to these populations, unless, it can be used for their political gain.

Difficulties in access are often, therefore, deliberately created in order to exploit the vulnerability of civilian populations for political, and sometimes, military purposes. As a result, relief agencies find themselves re-negotiating access agreements several times, with previously consented space now off limits and with vary-

ing factions en route to the intended target.<sup>41</sup> Variants of such tactics have been seen in Sudan, Angola, Ethiopia and Rwanda.<sup>42</sup> Often relief agencies are used to garner international attention for a cause or as a perceived means of legitimating the non-state actor, itself, as a stakeholder, and even power player in the given territory. At the extreme, the targeting and killing of civilians – refugee or otherwise – occurs as a means of attracting more NGOs.<sup>43</sup> Looking at the prism of aid delivery, it is not only a question of access but of whether the aid will reach its intended target. Within this process, however, relief agencies are being forced to negotiate creatively to accomplish their mission – often with no good choices. Such are the *lateral* tensions against which relief agencies increasingly find themselves having to push-back.

The reason the question of access and delivery is so critical to understanding this crisis is that it goes to the very heart of the conflict itself. HIV/AIDS is a systemic threat to the livelihood coping mechanisms that people employ when faced with shocks to the system as they know it. When aid delivery to an ailing community already experiencing micro-implosion of their household economies fails to occur, the crisis is further catalyzed, hastening its downward spiral. This is precisely why so many now argue that the role of humanitarian relief in complex emergencies is not only food aid, but also human security.

Relief organizations are increasingly placing themselves within the multiple webs of complex economies and armed conflict in order to safeguard those in need. Because of this, the very aid intended as relief is often diverted to clans or militias controlling the very territory one needs to access in order to make the intended deliveries.<sup>44</sup> Such was the case in Somalia, where theft and diversion were common. In fact, some of the same militias responsible for diversion would also force the NGOs to hire their services to guard relief supplies. In Sierra Leone and Liberia, “conflict analysts and medical NGOs learned that they could plan by following the pattern of UN food deliveries: when food was distributed to a village or displaced-person camp, the militias would quickly attack to steal relief supplies, killing dozens of villagers as they did so.”<sup>45</sup> In Sudan, both government forces and militias “unofficially appropriated” food aid, agricultural tools and even livestock taking it away from the weaker groups and giving it to the stronger ones.<sup>46</sup> All this is to say that the landscape of humanitarian aid as we know it has changed dramatically.

While over time the right to assist victims of “war” has come to include humanitarian agencies in their effort to grant independent and impartial assistance to civilians and the vulnerable, seldom are such agencies granted unfettered access in complex emergencies. Access still continues to be a major challenge for relief agencies. The results of such access limitations and denial “[have] been very evident in the Democratic Republic of Congo, where war is estimated to have caused over two million “excess deaths” (over and above natural wastage) in the population, including some 350,000

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deaths as a result of direct violence.”<sup>47</sup> As today’s crises typically manifest themselves through a wide-range of non-state actors, it is certainly difficult to know if international humanitarian law will even be acknowledged. Thus, the very issue of access and delivery is not guaranteed. In fact, negotiating access in the best of circumstances is becoming a great and consistent challenge for relief agencies. It remains now, however, to address the role of HIV/AIDS in this process.

### **Access and Delivery:**

#### **Unique Factors in Targeting the HIV/AIDS Afflicted**

The changing nature of access and delivery also applies with respect to the HIV/AIDS afflicted. Irrespective of the specific nature of the disease, the same systemic phenomenon is occurring. As non-state actors attempt to dismantle or hinder access and delivery mechanisms for the afflicted, relief organizations will be forced to creatively pursue and negotiate strategies to access their intended targets. Speaking strictly on the subject of access and delivery, therefore, relief agencies face the same challenges even with respect to HIV/AIDS.

What differentiates access and delivery in the case of the HIV/AIDS epidemic in Sub-Saharan Africa from other complex emergencies is the gravity that aid plays with respect to hindering the transformation of HIV to “full blown” AIDS. As previously discussed, malnutrition hastens the epidemic’s transformative process. As the explosive combination of malnutrition and HIV/AIDS is well documented, aid delivery to this population is critical.<sup>48</sup> This is true not only in order to stave massive death rates, but also prevent widespread economic collapse and its system repercussions.

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What also differentiates HIV/AIDS in general from standard humanitarian intervention is the level of stigma that occurs with respect to targeting those with HIV/AIDS. This, of course, is a critical issue on many levels; not the least of which is whether or not a relief agency could, in fact, accurately target the HIV/AIDS afflicted. This is true for two reasons. First, given the level of social stigma attached to HIV/AIDS in some parts of Africa, there is the risk of self-exclusion from any aid as a specific result of having the infection. People might simply feel too ashamed to participate in any local meetings to address the infection

and or programs of which they would otherwise welcome. Secondly, in some parts of Sub-Saharan Africa, there is active discrimination against those that are publicly known to have HIV. In some cases, people are deliberately excluded from relief assistance altogether. This is precisely why many advocates of HIV/AIDS relief caution humanitarian agencies against setting up policies and procedures that may, in fact, contribute to furthering such stigma.<sup>49</sup>

Clearly such unintended consequences should be avoided. However, what can-

not be avoided are the ethical questions that give rise to the issue of whether the combination of food shortage and HIV/AIDS, as a complex emergency, should be about the infection itself. While the percentages are exorbitantly high in Sub-Saharan Africa with respect to HIV/AIDS, not all members of communities where food shortages are occurring will, in fact, have the virus. The question then of whether it is ethical to specifically target the HIV/AIDS afflicted in face of general population needs and the potential stigma that differentiates such targeting from other complex emergencies is a valid one. In other words, is it ethical to target those afflicted with HIV/AIDS when one knows it may, in fact, harm them?

*Is it ethical to target those afflicted with HIV/AIDS when one knows it may, in fact, harm them?*

A final criterion that differentiates access and delivery to the HIV/AIDS afflicted from traditional aid relief is the very fact that it raises the question of whether the epidemic itself requires an immediate and short-term response as is typically the case in complex emergencies, or if it requires a long-term development strategy. On the one hand, it has been established that acute food shortages catalyze the process from HIV to AIDS due to weakened immune systems. On the other hand, the long-term impact due to AIDS deaths has the potential to be catastrophic at a system level. In the end, therefore, this article's answer to whether the HIV/AIDS crisis in Sub-Saharan Africa represents a complex emergency or development problem is actually quite clear. It is both.

Out of this multifaceted, deep, and complex crisis, perhaps one thing is clear. An entirely new way of thinking about complex emergencies is required. Is access and delivery then to the HIV/AIDS afflicted any different than traditional relief operations? Speaking strictly in terms of process, it is not. What makes it different, however, is: 1) the explosive combination of food shortage and HIV/AIDS; 2) the role of stigma and the question of whether targeting is even possible or, for that matter, ethical; and 3) the dual strategy of both immediate, short-term aid and long-term assistance that is needed to combat the epidemic's spread and consequences for individuals, households and the system as a whole.

## **Conclusion**

Today's relief agencies are the champions of working in conditions rife with uncertainty. Forced to push back against the *lateral* tensions of non-state actors, a failing state system and epidemics such as HIV/AIDS, relief agencies are now being forced to assume new roles on an unprecedented level by providing *tension* themselves within the confines of a new and constantly changing matrix. Increasingly, relief agencies find themselves operating in less than stable environments ridden with challenges in obtaining access to the very populations they need to serve. In this world of shifting variables, even the best negotiated access does not ensure deliverability. The first challenge then for the humanitarian community is not so much about how to get relief to HIV/AIDS populations in general, but how to do so in the first place given the opposing systemic forces at play. The second challenge is perhaps less daunting. How should relief agencies deal with acute complex emergencies that also require a

long-term development approach? And given that, what can the international community do to mitigate, if even possible, the inherent tension between the *top-down*, *bottom-up* and *lateral* forces currently pushing towards each other? Such are some of the areas of research that warrant further consideration. Whatever the answers, it is clear that for the humanitarian relief community to do its job, it will require a new way of not only looking at the problem, itself, but in dealing with this emergency.

### Endnotes

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