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Position Paper
HIV/AIDS in Southern Africa

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20 November 1998.

Background.

Southern Africa is currently experiencing the worst HIV epidemic in the world. HIV prevalence has risen to levels that seemed impossible a few years ago. Even more worrying is that the spread is far more uniform between rural and urban areas than was the case in Uganda and other East African countries. A quick review of the data from the region shows how serious the situation is. This is shown in Table 1, compiled from UNAIDS sources and the United Nations Human Development Reports. The first column shows the estimated national adult HIV prevalence, the second the number of people living with HIV and AIDS.

Table 1. HIV Prevalence, Infections, Orphans and Life Expectancy in SADC

Country	1. Est. adult prevalence	2. No. of adults & children living with HIV/AIDS	3. Est.no. of orphans	Life Expectancy		HDI Ranking	
				4. 1993	5. 1995	6. 1996	7. 1998
Angola	2.12	110 000	16 000	46.8	47.4	165	156
Botswana	25.10	190 000	25 000	65.2	51.7	71	97
D R Congo	4.35	950 000	310 000	52	52.4	141	143
Lesotho	8.35	85 000	8 500	60.8	58.1	130	134
Malawi	14.92	710 000	270 000	45.5	41	157	161
Mauritius	0.08	No data	No data	70.4	70.9	54	61
Moçambique	14.17	1 200 000	150 000	46.4	46.3	167	166
Namibia	19.94	150 000	7 300	59.1	55.8	116	107
Seychelles	-	-	-	-	64.1	60	56
South Africa	12.91	2 900 000	180 000	63.2	72.0	100	89
Swaziland	18.50	840 000	7 200	57.8	58.8	110	115
Tanzania	9.42	1 400 000	520 000	52.1	50.6	144	150
Zambia	19.07	770 000	360 000	48.6	42.7	136	146
Zimbabwe	25.84	1 500 000	360 000	53.4	48.9	124	130

Source: UNAIDS and WHO, **Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted diseases,** Geneva 1998 and available at www.UNAIDS.org

The consequence of HIV infection is that people will fall ill and die. The impact is most easily seen in terms of increased orphaning and decreased life expectancy. While an infected women has about a 30% chance of infecting her child with HIV, a child born to an infected mother has virtually a 100% chance of being orphaned. The number of living orphans is shown in the third column. There are a number of models of the impact of AIDS on life expectancy. Two have been published: the first in the annual Human Development Report produced by the United Nations Development Programme; the second by the US Bureau of the Census.[1]

The UNDP figures are shown in columns four and five of Table 1. It was only in the 1997 Human Development Report that AIDS mortality was considered as having an impact on life expectancy. The table shows 1993 life expectancy figures (in the 1996 report) and 1995 figures (from the 1998

[1] United Nations Development Programme, **Human Development Report 1996 and 1998,** Oxford University Press, New York 1996 & 1998. United States Bureau of the Census, **World Population Profile 1998,** Population Division International Programme Centre, Washington DC, 1998.

report). These figures have added significance, as life expectancy provides one third of the weighting for the calculation of the Human Development Index. As can be seen from the table (columns 6 and 7) the effect of the epidemic is to push down countries down the index.

It should be noted that the calculations by the US Bureau of the Census provide a rather bleaker picture for some of the SADC countries, and this is shown in Tables 2 and 3.

Table 2. Demographic Indicators for 1998 with and without AIDS

Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	40.1	61.5	121.1	57.4
Democratic Republic of Congo	49.3	54.4	152.7	139.3
Lesotho	54	62	120.2	98.3
Malawi	36.6	51.1	231.6	190.3
Namibia	41.5	65.3	125.5	62.1
South Africa	55.7	65.4	95.5	69.7
Swaziland	38.5	58.1	168.1	114.4
Tanzania	46.4	55.2	160.1	137.8
Zambia	37.1	56.2	181.2	125.7
Zimbabwe	39.2	64.9	123.4	50.5

Source: United States Bureau of the Census, **World Population Profile 1998**, Population Division International Programme Centre, Washington DC, 1998.

Table 3. Demographic Indicators for 2010 with and without AIDS

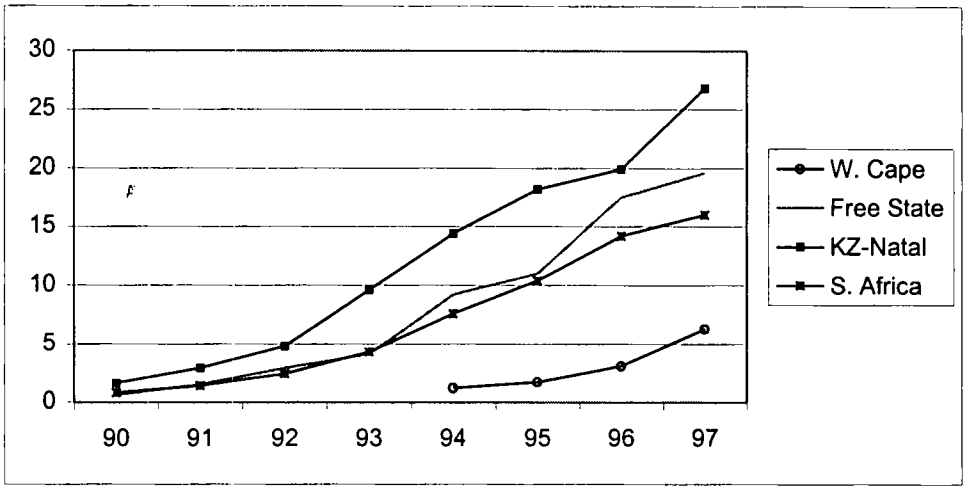
Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	37.8	66.3	119.5	38.3
Democratic Republic of Congo	51.9	59.8	116.2	97.3
Lesotho	44.7	65.9	121.9	70.7
Malawi	34.8	56.8	202.6	136
Namibia	38.9	70.1	118.8	37.5
South Africa	48	68.2	99.5	48.5
Swaziland	37.1	63.2	152.2	77.5
Tanzania	46.1	60.7	131.3	95.8
Zambia	37.8	60.1	160.7	96.9
Zimbabwe	38.8	69.5	115.6	31.8

Source: United States Bureau of the Census, **World Population Profile 1998**, Population Division International Programme Centre, Washington DC, 1998.

The data above are for nations. The situation in not uniform across countries. For example in South Africa the situation varies from province to province. The worst affected is KwaZulu-Natal, where the 1997 survey of ante-natal clinic attenders found an HIV prevalence rate of 26.9%. By contrast in the Western Cape it is 6.3 per cent. The variation in prevalence by province in South Africa is illustrated in Figure 1. The region is also where the highest HIV prevalence in a "low-risk" group

has ever been recorded. According to UNAIDS, in Beitbridge in Zimbabwe "HIV prevalence in pregnant women shot up from 32% in 1995 to 59% in 1996".[2]

Figure 1 HIV-positivity in women attending antenatal clinics in South Africa, by selected province overall (%)



Because the HIV rates have risen so rapidly, it is likely that the AIDS cases will show a similar rapid increase. The current situation is that in much of the region impact is restricted to the health care system, where 50 to 70 per cent of medical beds are occupied by people with HIV-related disease. In the medium-term there will be a range of demographic, economic, social, and security implications. The extent and magnitude of these is not yet clear, but it is a source of considerable concern for researchers and activists. Unfortunately these concerns do not appear to be shared by the majority of the governments, politicians, planners and policy-makers in the region.

The Response

The donor community is increasingly worried about the AIDS epidemic, and this is illustrated by the recent decision by UNAIDS and the WHO to launch a "Southern Africa Initiative on HIV/AIDS". SADC has recognised the importance of the HIV/AIDS epidemic to the region for some time. In part the impetus for SADC actions came from the joint EU/SADC Regional Conference on HIV/AIDS held in Lilongwe, Malawi in December 1996. The conference resulted in two key outcomes, a statement on regional responses to HIV/AIDS, a SADC Plan of Action, and two publications "Conference on HIV/AIDS: Proceedings and Background Papers" and "Conference on HIV/AIDS: Proposal for Regional Actions".

The SADC Plan of Action recognises that AIDS is not just a health issue and it requires co-ordinated social and economic policies. As well as identifying areas for regional support for national action, and interventions with added value if dealt with regionally, the plan has some specific proposals for action. These include the areas of employment; mining; education; tourism; medical drugs; and the treatment of people with HIV/AIDS; and the collection of data and exchange of information in the region.

At the SADC member states meeting in Mauritius in September 1998, HIV/AIDS was recognised as one of the Biennial Priorities for the Region. The meeting set 10 priorities and, as with the SADC Plan of Action, these recognise the need for a multi-sectoral response. SADC also has made further progress in that a Health Sector Co-ordinating Unit has been established in the Department of

[2] UNAIDS and WHO, **Report on the global HIV/AIDS epidemic, June 1998,** Geneva 1998.

Health in South Africa and the Director and Deputy Director took up their posts at the beginning of October 1998. The plans for this sector were adopted by the Council of Ministers and HIV/AIDS is one of the five priority areas for the sector. However it is likely that progress will be slow, as the staff in South Africa are junior and inexperienced. Furthermore SADC has to reflect the views of its member states, and unfortunately the reality is that in some countries AIDS is still not seen as a problem.

USAID and the SADC AIDS Crisis – one response.

USAID has been involved in the region for many years. As with most donors, it saw the ending of apartheid in South Africa as the chance for a new beginning for Southern Africa. It is now recognised that AIDS may well negate this opportunity and indeed could turn back the development clock. USAID is involved in one activity in the region that has the potential to assist in addressing the epidemic. The Project Award No. AOT-G-00-97-00375-00. Title: Operationalising HIV and AIDS, provides for a number of activities to be carried out by the Health Economics and HIV/AIDS Research Division of the University of Natal in Durban. It builds on work already carried out here with support from the European Commission of the European Union and USAID. In particular a toolkit was prepared for incorporating AIDS issues into the development activities of the European Union. This was published in French and English and is available on the World Bank AIDS Economics website as well as in hard copy form.

The activities under the contract are:

- Prepare new and update existing Sectoral AIDS Briefs. These were prepared under contract to the Global Programme on AIDS in 1995 and were published by The Academy for Educational Development with support from USAID in both French and English. Existing AIDS briefs include commercial agriculture; subsistence agriculture, education, health, manufacturing, mining, tourism, and the military. New briefs will include transport, financial sector, fishing, construction, small scale enterprises, entertainment and sport.
- Prepare AIDS briefs for professionals. The following briefs are in production: architects, relief workers, lawyers, town and regional planners, politicians, the media, social workers and NGOs.
- A Toolkit for Governments. This will set out activities to be carried out by the various ministries in government.
- A Toolkit for USAID. This will look at USAID activities and policy and make suggestions as to how AIDS can be incorporated into them.
- Training. The contract provides for training. Originally this was to be for government and other African officials. As this comes at the end of the project (which is scheduled to finish in September 1999) it could be adapted to fit USAID regional needs as well, both in Africa and Washington.