

The impoverishing pandemic

THE IMPACT OF THE HIV/AIDS CRISIS IN SOUTHERN AFRICA ON DEVELOPMENT

In most countries of the Southern African Development Community, HIV has assumed pandemic proportions. In this article, **Mary O' Grady** sets out the findings of a range of recent reports on the impact that HIV-related illness and death is having on human development and poverty in Southern Africa.

Introduction

Well over a third of the people with HIV/AIDS in the world at the end of 2003 were living in a single subregion, Southern Africa. As the epicenter of the global HIV/AIDS pandemic, Southern Africa continues to shoulder the major burden of the HIV/AIDS crisis in 2004. Southern Africa was home to an estimated 14.4 million people living with HIV/AIDS at the end of 2003, in a global total estimated by UNAIDS at 37.8 million. Moreover, more than 10 per cent of the people with HIV/AIDS in the world lived in a single country in this subregion, South Africa, estimated by UNAIDS to have 5.3 million people living with HIV at the end of 2003 (UNAIDS 2004:190-191).

In addition to having the largest number of people living with HIV/AIDS, Southern Africa was home to approximately 5.91 million orphans 'due to AIDS' at the end of 2003. According to UNAIDS, 1.2 million adults and children died from AIDS-related illness last year in Southern Africa (see Table 1). Overall, an average HIV prevalence rate of 17.9 per cent was found in adults aged 15 to 49 at the end of 2003, spread across 13 countries in Southern Africa. Yet the range of adult HIV prevalence rates across these countries last year was broad. Adult HIV prevalence rates in 2003 ranged from a high of 38.8 per cent in Swaziland in a total population of 1.1 million people to 1.7 per cent in Madagascar in a total population of nearly 17 million people (UNDP, 2004:154-155).

At the end of 2003 Southern African countries were also struggling to cope with nearly a million children (977 600) aged 14 or younger living with HIV/AIDS (UNAIDS, 2004:192). These numbers speak for themselves. It is hard to imagine any subregion in the world today effectively managing such an enormous challenge in the numbers of people who are ill, dying, and struggling to survive on a daily basis. For Southern Africa, where ten of its overall 16 countries are considered by the United Nations Development Programme (UNDP) to be 'low income,' or on the lowest rung economically of countries worldwide, with a gross national income (GNI) per capita of US\$732 or less in 2002 (UNDP, 2004:280),¹ the magnitude of the present pandemic and its potential multidimensional impact in the future is extremely difficult, if not impossible, to truly comprehend. Indeed, governments, foreign aid donors, and individuals generally cannot understand the breadth of the impact of the HIV/AIDS pandemic in Southern Africa to date for a variety of reasons. Some countries in the subregion have only begun to

¹ UNDP, 2004. These countries include Angola, Comoros, Democratic Republic of the Congo (DRC), Lesotho, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.

realise the extent of the mortality resulting from AIDS in the last few years, including South Africa (Dorrington *et al.*, 2001). This is the largest epidemic in human history (Jayamaha, 2002). Thus, there is no previous model to follow. Perhaps most significantly, nations in Southern Africa are trying to figure out how to cope with the HIV/AIDS crisis – albeit some more than others – amid a myriad other problems.

TABLE 1: ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV, ORPHANS, AND DEATHS FROM AIDS IN SOUTHERN AFRICA AT THE END OF 2003

COUNTRY	ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV	ESTIMATED NUMBER OF WOMEN AGED 15-49 LIVING WITH HIV	ESTIMATED NUMBER OF CHILDREN UNDER AGE 15 LIVING WITH HIV	ESTIMATED HIV PREVALENCE RATE IN ADULTS AGED 15-49	ESTIMATED NUMBER OF ORPHANS DUE TO AIDS	ESTIMATED NUMBER OF AIDS DEATHS IN ADULTS AND CHILDREN IN 2003
Angola	240,000	130,000	23,000	3.9%	110,000	21,000
Botswana	350,000	190,000	25,000	37.3%	120,000	33,000
Dem. Rep. of the Congo	1,100,000	570,000	110,000	4.2%	770,000	100,000
Lesotho	320,000	170,000	22,000	28.9%	100,000	29,000
Madagascar	140,000	76,000	8,600	1.7%	30,000	7,500
Malawi	900,000	460,000	83,000	14.2%	500,000	84,000
Mozambique	1,300,000	670,000	99,000	12.2%	470,000	110,000
Namibia	210,000	110,000	15,000	21.3%	57,000	16,000
South Africa	5,300,000	2,900,000	230,000	21.5%	1,100,000	370,000
Swaziland	220,000	110,000	16,000	38.8%	65,000	17,000
Tanzania	1,600,000	840,000	140,000	8.8%	980,000	160,000
Zambia	920,000	470,000	85,000	16.5%	630,000	89,000
Zimbabwe	1,800,000	930,000	120,000	24.6%	980,000	170,000
TOTAL/AVERAGE	14,400,000	7,626,000	976,600	17.9%	5,912,000	1,206,500

Data source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2004 Report on the Global AIDS Pandemic. Note: Totals/averages in this table for Southern Africa were compiled using the data in the UNAIDS report.

The governmental response to HIV/AIDS in Southern Africa has been slow, although a few heads of state have begun to demonstrate exemplary leadership. In December 2000, President Festus Mogae of Botswana spoke to the African Development Forum of the Economic Commission on Africa in Addis Ababa, Ethiopia, on 'AIDS: The Greatest Leadership Challenge', stating that 'Africa is facing the greatest challenge ever known to man. The impact of HIV/AIDS on the population, the economy, and the very fabric of our society undermines not only development, but poses a serious threat to our security and life as we know it'.²

Botswana was then in the process of planning a programme to provide free antiretroviral therapy (ART) to its population, the first country in Africa to take this step, based on having the highest HIV prevalence rate in the world at the time. The country began its ART initiative in 2002 at four central sites. By July 2003, 10 415 people in Botswana were enrolled in the programme, of some 110 000 people estimated to be in need of ART (Stewart, *et al.* 2004:11). By marshalling international support for its response to the epidemic and partnering internationally with experts from pharmaceutical companies, universities, donor agencies, non-governmental organisations (NGOs), and by utilising the services of interested foreign medical personnel, Botswana is the only country in Southern Africa that thus far has shown strong leadership on HIV/AIDS (UNAIDS 2004:169).

More recently, the government of Zambia declared its HIV/AIDS epidemic as a 'state of emergency,' specifying the period August 2004 to July 2009. This declaration, which will allow Zambian companies to manufacture generic antiretroviral medications, was engineered to comply with World Trade Organization (WTO) agreements on patented pharmaceutical products. Currently, some 12 000 Zambians are receiving subsidised ART through the government's programme, and the emergency declaration and subsequent national ART production will allow a scale-up of government ART provision to treat an estimated 100 000 more Zambians by the end of 2005 (*Mail & Guardian*, 4 September 2004).

While some countries in Southern Africa have begun more focused and long-term responses to their HIV/AIDS epidemics, controversies continue in others. South Africa should be the subregional leader in its HIV/AIDS response based on the number of people living with HIV – more than five million, the highest number of any country in

² Economic Commission on Africa, 2004. Statement by H.E. Festus G. Mogae, President of Botswana. http://www.uneca.org/adf2000/daily_updates/speeches_and_press_releases/120700stat.

the world (see Table 1) – and because it is the economic powerhouse of the continent (UNAIDS, 2002). But this is one issue South Africa is refusing to provide leadership on.

Action by civil society

Government inaction in South Africa has led to a number of legal battles centered on HIV/AIDS (The Policy Project 2003:98). In 2002, for example, the Treatment Action Campaign (TAC) law suit against the South African government was decided successfully in the country's Constitutional Court, entitling pregnant South African women nationwide who are living with HIV, as well as their newborns, to receive the antiretroviral drug nevirapine, in order to reduce the transmission of HIV to their babies. This year the TAC and its partner, the AIDS Law Project (based at South Africa's University of the Witwatersrand) are once again contemplating legal action regarding the fact that the Minister of Health has not released the detailed treatment targets and time-lines for its national ARV roll-out operational plan, issued in November 2003³. Also considered to be a public document, the more detailed annexure of the government's national ART plan should have laid out how the government expected to enroll 50 000 South Africans, its previously stated target, in ART by the end of 2004 (*Mail & Guardian*, 13 September 2004).

The tragedy of the latest TAC legal action underscores again the inaction of South Africa's Department of Health in urgently treating the 400 000 to 500 000 South Africans the government, in November 2003, claimed would benefit from AIDS drugs (*Business Day*, 14 September 2004). That 370 000 South Africans died of AIDS-related illness in 2003 (see Table 1), according to UNAIDS (2004:193), is a stark contrast to the mere 8 000 on ART nearly a year later, entering 2004's fourth quarter.

Shorter life expectancy in the subregion

Frequently cited as a major consequence of the HIV/AIDS pandemic in Southern Africa is the reversal of development gains made in the subregion over the last 30 years. Originally researched and then released by the U.S. Department of the Census's International Programs Center at the XIII International Conference on AIDS held in Durban, South Africa, in July 2000, statistics on life expectancy at birth for Southern African countries – resulting from the impact of the various national HIV/AIDS epidemics

³ At the time of writing, a national protest was being planned for November 4th, 2004.

– were shocking (Haney, 2000). Most striking was the change in life expectancy at birth for Zimbabweans, from 56 years in 1970-1975 to 33.1 in 2000-2005, the loss of nearly 23 years of life, according to current UNDP data (see Table 2). Closely following in the loss of years of life was Zambia, with its life expectancy plummeting from 49.7 years in 1970-1975 to 32.4 years in 2000-2005, more than a 17-year drop ending in the lowest life expectancy in the world. Botswana showed a life expectancy trend downward from 56.1 years in 1970-1975 to 39.7 years in 2000-2005, more than 16 years, while Lesotho's life expectancy figures dropped from 49.5 years in 1970-1975 to 35.1 in 2000-2005, indicating a loss of 14.4 years of life (UNDP, 2004:170-171).

The link between HIV and reduced life expectancy is demonstrated through the fact that the only two countries in Southern Africa seeing a continued rise in life expectancy have adult HIV prevalence rates under five per cent, considered the cut-off for a generalised nationwide epidemic. Ironically, life expectancy at birth in Madagascar grew from 44.9 years in 1970-1975 to 53.6 years in 2000-2005, showing an increase of 8.7 years. In Angola, despite its continuing struggle to overcome its recent war-torn past, life expectancy was 38.0 years in 1970-1975, while in 2000-2005 it is 40.1, a gain of 2.1 years. These life expectancy figures are telling for countries in other regions facing growing HIV/AIDS epidemics. An anachronism in the subregion, however, is the Democratic Republic of the Congo (DRC), which showed a decrease in life expectancy from 45.8 years in 1970-1975 to 41.8 in 2000-2005, despite having an adult HIV prevalence rate of only 4.2 per cent (UNDP, 2004:170-171). With its ongoing problems of governance, as well as socio-economic and health challenges, and the difficulty of obtaining accurate health statistics nationwide, the DRC's HIV prevalence rate could be higher than the present UNAIDS estimate, whether or not the life expectancy of its citizens is being influenced by a wide variety of factors beyond HIV/AIDS.

TABLE 2: HUMAN DEVELOPMENT INDEX, HUMAN POVERTY INDEX AND OTHER DEVELOPMENT FACTOR RANKINGS IN SOUTHERN AFRICA

COUNTRY	HDI RANK 2002 AND VALUE	HDI VALUE 1990	HPI-1 RANK 2002 AND VALUE	LIFE EXPECTANCY AT BIRTH 1970-1975	LIFE EXPECTANCY AT BIRTH 2000-2005	ADULT LITERACY RATE AGE 15 AND ABOVE 2002
South Africa	119 /0.666	0.729	52 /31.7	53.7	47.7	86.0%
Namibia	126 /0.607	N/A	64 /37.7	49.9	44.3	83.3%
Botswana	128 /0.589	0.675	76 /43.5	56.1	39.7	78.9%
Swaziland	137 /0.519	0.611	N/A	47.3	34.4	80.9%
Lesotho	145 /0.493	0.544	85 /47.9	49.5	35.1	81.4%
Zimbabwe	147 /0.491	0.617	91 /52.0	56.0	33.1	90.0%
Madagascar	150 /0.469	0.436	58 /35.9	44.9	53.6	N/A
Tanzania	162 /0.407	0.413	59 /36.0	46.5	43.3	77.1%
Zambia	164 /0.389	0.466	90 /50.4	49.7	32.4	79.9%
Malawi	165 /0.388	0.368	83 /46.8	41.0	37.5	61.8%
Angola	166 /0.381	N/A	N/A	38.0	40.1	42.0%
Dem. Rep. of the Congo	168 /0.365	0.414	75 /42.9	45.8	41.8	N/A
Mozambique	171 /0.354	0.310	89 /49.8	41.1	38.1	46.5%

Data source: United Nations Development Programme, *Human Development Report 2004*

Southern Africa and the Human Development Index (HDI)

The Human Development Index (HDI) is used by the UNDP as a composite index to measure average national achievement in three basic dimensions of human development, including a long and healthy life, knowledge, and a decent standard of living (UNDP, 2004:271). The UNDP aggregates a total of 177 countries as 'high human development,' 'medium human development, or 'low human development.' All of the countries in Southern Africa are designated by the UNDP as either medium or low in the HDI. Only seven Southern African countries qualify as medium on the HDI, and four of these have significant HIV/AIDS epidemics: Botswana, Namibia, South Africa and Swaziland. The Southern African island nations of Comoros, Maldives and Mauritius have

successfully avoided HIV/AIDS epidemics to date. Yet the nine countries in Southern Africa considered by the UNDP to fall into the low range on the HDI all suffer extensive HIV/AIDS epidemics in addition to other inhibiting developmental factors, and include Angola, DRC, Lesotho, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe (UNDP, 2004:279).

The indicators included in the HDI's longevity, knowledge, and a decent standard of living country ratings include life expectancy at birth to equate with a long and healthy life; the adult literacy rate and the combined gross enrolment ratio for primary, secondary and tertiary schools to capture knowledge; and the gross domestic product (GDP) per capita to encompass a decent standard of living. The highest ranked country as of 2002 in Southern Africa is South Africa, at 119. However, it is important to note that South Africa's HDI value has declined, from 0.729 in 1990 to 0.666 in 2002 (see Table 2). Surely, the downward trends in life expectancy at birth based on the impact of the various Southern African countries' HIV/AIDS epidemics were a factor in the country rankings and their mostly decreasing values in the HDI. Yet again, the most striking decline is seen when comparing Zimbabwe's 1990 value of 0.617 with its 2002 value of 0.491. Once considered the breadbasket of Southern Africa (Thurow, 2003), Zimbabwe ranked 147 on the UNDP HDI of 2004 comprising 177 countries.

Tragically, only three Southern African countries fared marginally better in their HDI values in 2002 than in 1990: Madagascar, which increased its HDI value from 0.436 in 1990 to 0.469 in 2002; Malawi, which increased its HDI value in 1990 from 0.368 to 0.388 in 2002; and Mozambique, which increased its HDI value from 0.310 in 1990 to 0.354 in 2002 (UNDP, 2004:145-146). Nevertheless, these upward values are not large.

Southern Africa and the Human Poverty Index (HPI-1)

The Human Poverty Index (HPI-1) is used by the UNDP specifically for 95 developing countries as a measurement of deprivations in the three basic dimensions captured in the HDI, including a long and healthy life, knowledge, and a decent standard of living (UNDP, 2004:271). This paper does not report on the indicators used by the UNDP to create the HPI-1, including the probability at birth of not surviving to age 40; the adult illiteracy rate; the percentage of the population without access to an improved water source, and the percentage of children underweight for their age indicating deprivation

in a decent standard of living. The HPI-1 rankings of Southern African countries for which data were available as of 2002 and included in the *Human Development Report 2004* are listed in Table 2. The rankings in descending order start with South Africa at 52; Madagascar at 58; Tanzania at 59; Namibia at 64; DRC at 75; Botswana at 76; Malawi at 83; Lesotho at 85; Mozambique at 89; Zambia at 90; and, Zimbabwe at 91. Clearly, life expectancy at birth, which is being affected by national HIV/AIDS epidemics in the subregion, influences the probability of not surviving to age 40. Similarly, Mozambique's low adult literacy rate of only 46.5 per cent must have had an impact on its low ranking on this poverty list in addition to its low life expectancy at birth, partly based on its worsening HIV/AIDS epidemic (UNAIDS, 2004:190-191).

Health, politics, and the economy

One of the impacts of the HIV/AIDS pandemic globally is a more profound realisation of the importance of human health on socio-economic development or the lack thereof. While health experts have long been aware of the importance of infant mortality, child mortality, and life expectancy at birth figures and ratings, the development community across the board has not considered the overall burden of disease to be of central importance to socio-economic growth or diminution. According to the World Health Organization's 2001 report of its Commission on Macroeconomics and Health, not only is improving the health and longevity of the impoverished a goal in itself, but it is a means to achieving other socio-economic development goals relating to poverty reduction. Consequently, the burden of disease in regions such as sub-Saharan Africa, particularly in light of the extensive HIV/AIDS pandemic in this region, is an enormous and growing barrier to development (Sachs, *et al.* 2001:1). The response needed to the challenge of HIV/AIDS is both urgent and intense. Indeed, the key recommendation of this commission's report was that the world's low- and middle-income countries, in partnership with its high-income countries, should scale up the access of essential health services and specific interventions to the world's impoverished people (Sachs, *et al.* 2001:4).

In examining socio-economic development in Southern Africa using the UNDP's GDP listings for the countries, South Africa dwarfs all the other countries in the subregion (see Table 3). Its GDP for 2002, equivalent to more than US\$104 billion, was nearly 150 times that of Lesotho's at US\$0.7 billion, which it geographically surrounds. Nonetheless, South Africa's neighbour, Botswana, maintained a higher GDP per capita in 2002 at US\$3 080, compared to South Africa's US\$2 299. Both of these GDP per capita figures tower over that of the DRC in 2002 at US\$111. But because Mozambique has a significantly smaller total population at 18.5 million than the DRC at 51.2

million, Mozambique had a higher per capita GDP at US\$195 than the DRC (UNDP, 2004:154-155). Even so, Mozambique ranks 171 on the list of 177 countries for which the UNDP ranked GDP, and thus it falls into the 'low human development' category (UNDP, 2004:187).

Comparing the GDP statistics of Southern African countries in 2002 shows a fairly broad range of development in the subregion (see Table 3). Yet the socio-economic development landscape varies from South Africa's 'world-class' cities of Cape Town and Johannesburg to the stressful and distressing living conditions in long-time political pariah the DRC, from which many people have sought refuge since the 1960s, according to the UN's Office for the Coordination of Humanitarian Affairs.⁴ Then there is the ongoing degradation of socio-economic conditions, as well as democracy, in Zimbabwe, where its population experienced more than 600 per cent inflation between January 2003 and January 2004 (*Mail & Guardian*, 13 February 2004).

The impact of political and economic crises on health generally, and HIV/AIDS in particular, is not difficult to discern. According to a report from Zimbabwe in March 2004, 'Hospitals have no equipment or medicines and few qualified staff. A patient with a fracture is told to bring plaster of paris before his bone can be set. ... Doctors' fees, hospitals and medicines are unaffordable except for the elite, and many procedures are no longer provided in the country. ... Many educational and medical professionals have left the country.'⁵ Furthermore, HIV is not the only epidemic the subregion confronts. The 90 per cent deadly Ebola virus was discovered in the DRC in 1976 (Sanchez, 1995), and there are still periodic outbreaks of this disease. Malaria is endemic in parts of various Southern African countries and throughout much of the region (CDC, 2004).⁶ South Africa has one of the highest co-infection rates of HIV/AIDS and tuberculosis (TB) in the world, the latter of which kills more people with HIV/AIDS in developing countries than any other 'opportunistic infection.'⁷ Thus health generally needs to receive a greater prioritisation from the region's governments, something they have recognised but rarely acted upon.

⁴ Irin News, 7 November 2003. DRC-Zambia: refugees flee fighting. Lusaka: UN Office for the Coordination of Humanitarian Affairs. <http://www.irinnews.org/print.asp?ReportID=37733>.

⁵ Ndlovu, M. 4 March 2004. Zimbabwe in March 2004: four years from the beginning of the plunge. *Pambazuka News* 146.

⁶ Centers for Disease Control, 2004. Malaria: geographic distribution. http://www.cdc.gov/malaria/distribution_epi/distribution.htm.

⁷ TB on the rise due to HIV. 25 March 2004. Johannesburg: *The Star*.

TABLE 3: GROSS DOMESTIC PRODUCT (GDP) AND HEALTH EXPENDITURES IN SOUTHERN AFRICA

COUNTRY	TOTAL POPULATION MILLIONS 2002	GDP US\$ BILLIONS 2002	GDP US\$ PER CAPITA 2002	HEALTH EXPENDITURE 2001 PUBLIC (% OF GDP)	HEALTH EXPENDITURE 2001 PRIVATE (% OF GDP)	HEALTH EXPENDITURE 2001 PER CAPITA (PPP US\$)
South Africa	44.8	104.2	2,299	3.6	5.1	652
Namibia	2.0	2.9	1,463	4.7	2.2	342
Botswana	1.8	5.3	3,080	4.4	2.2	381
Swaziland	1.1	1.2	1,091	2.3	1.1	167
Lesotho	1.8	0.7	402	4.3	1.2	101
Zimbabwe	12.8	8.3	639	2.8	3.4	142
Madagascar	16.9	4.4	268	1.3	0.7	20
Tanzania	36.3	9.4	267	2.1	2.3	26
Zambia	10.7	3.7	361	3.0	2.7	52
Malawi	11.9	1.9	177	2.7	5.1	39
Angola	13.2	11.2	857	2.8	1.6	70
Dem. Rep. of the Congo	51.2	5.7	111	1.5	1.9	12
Mozambique	18.5	3.6	195	4.0	1.9	47

Data source: United Nations Development Programme, *Human Development Report 2004*

Reviewing UNDP's health expenditure statistics for countries in 2001 (see Table 3) to discern whether they reflect government commitment to responding to the HIV/AIDS epidemics in the subregion gives one pause (UNDP, 2004:158-159). South Africa's reversal in 2003 of its earlier equivocating on whether to provide ART to people with AIDS and the subsequent inclusion of related costs in its 2004 budget obviously would not be visible in 2001 figures. However, it is worth noting its composite public and private health expenditures constituted 8.7 per cent of its GDP in 2001 – higher than any other country in the subregion. Ironically, South Africa's health expenditure figure is closely followed statistically by Malawi, a UNDP-designated country of 'low human development,' which showed a composite of public and private health expenditures in 2001 as 7.8 per cent of GDP. Yet South Africa's per capita expenditure on health in 2001 – calibrated by the UNDP using PPP, or 'purchasing power parity,' to account for

price differences across countries to show the same purchasing power in the domestic economy as \$1 has in the United States (UNDP, 2004:274) – was US\$652, by far the highest of any country in the subregion. South Africa’s closest rival in 2001 was Botswana, at US\$381 per capita, which makes sense, given Botswana’s seriousness at the time in starting to launch a comprehensive response to its daunting HIV/AIDS epidemic.

In looking more closely at the numbers, though, it is important to note that South Africa’s private health expenditures in 2001 comprised 5.1 per cent of its GDP versus public health expenditures at 3.6 per cent of GDP. This shows its citizens generally were paying out of pocket more than they were accessing public health programmes for their health care; that is, the minority of South Africans who could afford to pay their own health costs or had them paid by their employers. It is questionable whether figures for 2004 to date would show much of a change, given the laggardly ART roll-out. Indeed, the extent of the roll-out so far is troubling for a variety of reasons, including that some two-thirds of households coping with HIV/AIDS in South Africa reported in a recent study a fall in household income because of the disease burden, and many were already very impoverished (Steinberg, *et al.* 2002:16). Further, households spent on average more than a third of their income on medical expenses (34 per cent), and those in which a member died spent four times the total household monthly income on the funeral (Steinberg, *et al.* 2002:18-19).

Individuals suffering ill health in Zimbabwe also received less government support for their needs, as described previously herein, than they spent themselves. Furthermore, the health expenditure figures for the DRC in 2001 are notable: the per capita health expenditure was only US \$12, and public health funding comprised only 1.5 per cent of the country’s GDP. While Madagascar’s 2001 per capita GDP health expenditure was US \$20, and only 1.3 per cent of its GDP went towards public health expenditures that year (UNDP, 2004:158), its HIV prevalence rate in adults in 2004 is estimated by UNAIDS at 1.7 per cent (UNAIDS, 2004:191). More troubling in retrospect is a review of Swaziland’s public health expenditure of 2.3 per cent of its GDP in 2001, while an additional 1.1 per cent of its GDP was spent by its citizens on their health care out of pocket. These figures add up to 3.4 per cent of GDP, mirroring the DRC’s health expenditures in 2001. Yet Swaziland’s health expenditure per capita of GDP was US\$167 in 2001, 13 times that of the DRC’s per capita health expenditure that year. Nonetheless, the Swaziland health expenditure statistics for 2001, on the low side, are significant because of its 38.8 per cent HIV prevalence rate in adults at the end of 2003, the highest in the world (UNAIDS, 2004:191).

The aforementioned GDP expenditures on health and all of those listed in Table 3 are of special concern compared with the commitments of 'at least 15% of our annual budget to the improvement of the health sector' made by African heads of state at the Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases held in Nigeria on 26-27 April 2001.⁸ This commitment to health by African leaders was itemised a few months later in the formal Declaration of Commitment on HIV/AIDS resulting from the UN General Assembly Special Session on HIV/AIDS (UNGASS), held in New York on 25-27 June 2001.⁹ The lack of significant follow-up to these commitments again highlights the dearth of leadership in the subregional response to its serious health crisis and understanding of the resulting and expanding socio-economic development needs.

The impact of HIV/AIDS on Millennium Development Goals

In considering the importance of a selected set of health indicators for Southern African countries shown in Table 4, one should keep in mind not only the influence of the HIV/AIDS epidemics on these indicators, but also the significance of these indicators in moving toward – or away from – the Millennium Development Goals (MDGs). A set of eight goals for development progress, the MDGs were adopted by 189 countries at the United Nations Millennium Summit held in New York in September 2000. In fact, these eight goals are bolstered by 18 targets and 48 indicators, establishing time lines for advancing development and reducing poverty around the world by 2015 or before. The UNDP has noted in its 2004 Human Development Report that the goal for reducing child mortality by two-thirds will not be met in sub-Saharan Africa until 2106; at the current pace, according to the UNDP, sub-Saharan Africa will not reach this goal until 101 years from now. And it could get worse, based on the impact of the HIV/AIDS pandemic over time and the regional situation generally. Goal 6 of the MDGs is 'Combat HIV/AIDS, malaria and other diseases' while Target 7 is 'Have halted by 2015 and begun to reverse the spread of HIV/AIDS' (UNDP, 2004:135). It is hard to imagine that the spread of HIV/AIDS in Southern Africa will have halted ten years from now unless current prevention efforts and treatment programmes are vastly scaled up locally, nationally and subregionally.

⁸ Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases. 27 April 2001. Abuja: Organisation of African Unity (OAU) and African Development Forum 2000. <http://www.uneca.org/adf2000/Abuja%20Declaration.htm>.

⁹ Declaration of commitment on HIV/AIDS: global crisis-global action. New York: United Nations. <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>.

The UNDP specifies in its Human Development Report 2004 that in reality no date can be set for sub-Saharan Africa to reach three of the goals: decreasing hunger, lessening poverty, and increasing access to sanitation. For these three factors, the regional situation 'is worsening, not improving' (UNDP, 2004:132). Moreover, the UNDP identifies a number of Southern African countries in a series of tables in its Human Development Report 2004 showing 'best performers' and 'worst performers' on several MDGs between 1990 and 2002. For example, on child mortality, three countries in the subregion are listed among the six worst performers in the world: Botswana, Zimbabwe and Swaziland, in descending order. The child mortality situation in each of these countries worsened appreciably between 1990 and 2002. In Botswana, child mortality nearly doubled, from 58 deaths per 1 000 live births in 1990 to 110 deaths per 1 000 live births in 2002. Given the country's per capita GDP at US \$3 080, the highest in the subregion, and other factors, the only plausible explanation for this doubling is that Botswana's adult HIV/AIDS prevalence rate, estimated at 37.3 per cent at the end of last year (UNAIDS, 2004:191), is influencing child mortality and the HIV prevalence rate in children. Swaziland, too, must have felt an impact on its child mortality between 1990 and 2002 at least partly resulting from its very high adult HIV/AIDS prevalence rate of 38.8 per cent at the end of 2003. Furthermore, Swaziland's child mortality rate in 1990 was 110 per 1 000 live births, where Botswana's rate was in 2002, while in 2002 Swaziland's had zoomed up to 149 deaths per 1 000 live births (UNDP, 2004:132).

Noteworthy as well on the UNDP's latest development report's best and worst performers lists were Angola and the DRC, based on their performances between 1990-1991 and 2001-2002 in primary education. Both were among the top three 'worst performers' in the world in this category. Further representing the subregion, Zimbabwe led the pack of 'poor performers' in 'income poverty,' gauged over five years between 1990-1991 and 1995-1996, losing 9 percentage points. Ironically, the Mugabe government's land reform policy, presaging huge drops in the country's socio-economic status, was put into action only in 2000. Clearly, the country was already on a downward incline on the impoverishment scale. Last but not least, eight Southern African countries, in a total of 20 worldwide, dropped in the HDI between 1990 and 2002, as summarised previously herein – Botswana, DRC, Lesotho, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. With the MDGs starting to loom in the minds of development planners, even though the final targets are eleven years hence, Southern Africa unquestionably needs to recognise that a co-ordinated and urgent response to HIV/AIDS and health is now vital to improve its socio-economic development situation.

With the aforementioned MDG information in one's mind, scanning Table 4 should be more meaningful, both in the child mortality rate listings and regarding the statistics on the probability at birth of survival to age 65. The HIV/AIDS epidemics in these countries will have had an impact on these statistics, as well as on infant mortality rates. South Africa's infant mortality rate in 2002 was the lowest in the subregion, an indicator of which the country should be proud. While this indicator cannot be measured against the infant mortality situation in South Africa in 1970 using UNDP data, South African government data has shown its infant mortality rate increased from 40 per 1 000 live births in 1991 to 45 per 1 000 live births in 1998 (Office of the Presidency, 2003:21)¹⁰ to the present figure used by the UNDP. If the country's HIV/AIDS epidemic continues to worsen, especially among pregnant women, South Africa's position heading the list in keeping infants alive in the subregion could change. Indeed, while a quick scan of this table indicates some significant infant and child health gains made in some countries from 1970 to 2002, it is important to keep in mind that HIV/AIDS epidemics are starting to reverse these gains, as has been seen in South Africa. Zambia's infant mortality rate has hardly changed, according to the UNDP, between 1970 and 2002 (UNDP, 2004:171). While the health situation in Zambia has not improved relative to most other countries in the subregion in 30 years, the fact that the country has experienced a major HIV/AIDS epidemic for some 15 years must have had an impact on its infant mortality rates.

¹⁰ Policy Co-ordination and Advisory Services. Towards a ten year review: synthesis report on implementation of government programmes. October 2003. South Africa: Office of the Presidency.

TABLE 4: SELECTED HEALTH INDICATORS IN SOUTHERN AFRICA

COUNTRY	INFANT MORTALITY RATE 1970 (PER 1,000 LIVE BIRTHS)	INFANT MORTALITY RATE 2002 (PER 1,000 LIVE BIRTHS)	UNDER FIVE MORTALITY RATE 1970 (PER 1,000 LIVE BIRTHS)	UNDER FIVE MORTALITY RATE 2002 (PER 1,000 LIVE BIRTHS)	PROBABILITY AT BIRTH OF SURVIVAL TO AGE 65 2000-05 FEMALE	PROBABILITY AT BIRTH OF SURVIVAL TO AGE 65 2000-05 MALE
South Africa	N/A	52	N/A	65	37.4%	24.9%
Namibia	104	55	155	67	30.8%	24.7%
Botswana	99	80	142	110	21.7%	17.3%
Swaziland	132	106	196	149	15.2%	11.0%
Lesotho	128	64	190	87	19.2%	8.5%
Zimbabwe	86	76	138	123	8.3%	9.2%
Madagascar	109	84	180	136	51.5%	46.7%
Tanzania	129	104	218	165	29.2%	26.1%
Zambia	109	108	181	192	10.6%	11.3%
Malawi	189	114	330	183	21.3%	19.7%
Angola	180	154	300	260	31.1%	26.4%
Dem. Rep. of the Congo	148	129	245	205	31.4%	27.9%
Mozambique	163	125	278	197	26.3%	19.8%

Data source: United Nations Development Programme, *Human Development Report 2004*

The under-five mortality rates in Table 4 also show the effect of severe socio-economic and health development challenges in several countries in Southern Africa. Under five mortality figures, too, will have been affected by 2002 by the HIV/AIDS epidemics in the countries in the region with high adult HIV prevalence rates – especially those with long-standing epidemics – whether or not other issues played a role in determining the health of the children under five captured, tragically, in these statistics. Of note are the Malawi, Angola and DRC statistics from 1970, when two to three or more of every ten children born in these countries did not live to the age of five. Angola and the DRC in 2002 still measured up poorly, with more than two of every ten children born in the country dying before the age of five (UNDP, 2004:170-171).

Gender concerns arise in Table 4, beyond the infant and child mortality statistics, as the health and life of the mother will have an impact on the rearing of infants and children under five. Gender differences are evident in the disaggregated by sex statistics on the probability of survival to age 65, determined by the UNDP using a cohort basis. In both Zambia and Zimbabwe, which have endured major HIV/AIDS epidemics of at least 15 years' duration, more men than women during the years 2000-2005 were estimated to survive to the age of 65. In Zimbabwe's case, only 8.3 per cent of women in the country, that is, less than one in ten, will live to age 65. In South Africa, despite its socio-economic leadership in the subregion, less than half of women – 37.4 per cent – will see the age of 65. In Swaziland, only 15.2 per cent of women will see the age of 65, and in Zambia, only 10.6 per cent will reach 'retirement age.' These figures emphasise the degree of ill health across the subregion. Yet they also harken to the true, deep, and most likely long-lasting toll the HIV/AIDS pandemic is taking on Southern Africa, with a growing impact on women.

Impact of HIV/AIDS in Southern Africa on women

For at least ten years some HIV/AIDS specialists have presented data internationally showing higher adult HIV prevalence rates in women in sub-Saharan Africa than men. According to UNAIDS, based on their HIV/AIDS statistics for the region at the end of 2003, 57 per cent of adults living with HIV in sub-Saharan Africa were women, and even more strikingly, 75 per cent of the young people living with HIV were young women and girls (UNAIDS, 2004:22). In Southern Africa, the percentage is even higher: in Zambia and Zimbabwe young women and girls comprise nearly 80 per cent of the young people aged 15 to 24 living with HIV/AIDS, according to the World Health Organization's figures for 2001-2002 (United Nations, 2004:8).

Why are more women than men infected with HIV in sub-Saharan Africa, with even starker gender differences evident in Southern Africa? According to the International Labour Office (ILO) of the United Nations, 'Discrimination against women is probably universal, although much worse in some societies than in others' (ILO, 2004:126). In Southern Africa, especially in rural areas, women are often treated as legal minors. Customs can bar them from owning or inheriting property, or the laws entitling them to do so are not enforced. Some women are not allowed to make independent financial decisions, and many have very small amounts on which to make financial decisions in any case. Women, more than men, are more vulnerable to poverty and to exploitation,

including sexual exploitation and violence, as well as sexual violence (UN, 2004:8). Rape by a man infected with HIV exposes a woman to the virus through the abrasion or tearing of vaginal tissues, and can increase the risk of infection dramatically (UNFPA, 2004:84). In 2004 South Africa's crime statistics, among the highest in the world, are still rising in some categories, including rape. More than 52 000 cases of rape were reported in South Africa between April 2003 and March 2004, and these figures are only for the cases reported (*The Star*, 21 September 2004).

Even though victims of crime would be likely to be concerned with various impacts from the event, many women in Southern Africa remain unaware of their high degree of risk of HIV infection. In a project carried out in Zimbabwe from 1998 to 2001, a number of the women living with HIV stated they were unaware of their risk of HIV infection before they were tested (UNFPA, 2004:70). The UNFPA states in its recently released report, *The State of the World Population 2004*, 'Married girls are less likely than others their age to finish school, and more likely to contract HIV or another STI' (UNFPA, 2004:5). Since many sexually transmitted infections (STIs) are asymptomatic in women, or women are not aware of their STI symptoms and what they denote, they remain unaware of their risks on a variety of levels. They do not realise that having an STI makes them more vulnerable to HIV infection, for example (Wilkinson, *et al.*, 1997), including infection from their husbands, long-term sexual partners, or boyfriends they've known for only a few months whom they have decided seem trustworthy. There is a significant need to disentangle, especially in Southern Africa, trustworthiness from HIV infection. One is a values concept meaning different things to different people; the other is a potentially deadly disease.

As already discussed, Southern Africa is one of the most impoverished subregions in the world. Already suffering widespread poverty, and great economic inequality in some countries, most visibly in South Africa, many communities are now reeling from HIV/AIDS; and this individual, as well as community, burden is falling disproportionately on women and girls. More households in Southern Africa are headed by women than in any other part of sub-Saharan Africa, according to the U.N. Botswana heads the list at 52 per cent; Namibia follows at 47 per cent and South Africa runs a close third at 46 per cent. In the subregion as a whole, more than 34 per cent of the households with children are headed by women, nearly double the rate in West Africa, which has a much lower average HIV prevalence rate in adults than Southern Africa (UN, 2004:8).

In Africa, according to the ILO, many women are not considered to be part of the labour force. Yet they grow food, they run homes, and they care for children (ILO HIV/AIDS report, 2004:7). Globally, women generally have less employment security than men (ILO economic security report, 2004:156), yet what little security women have in Southern Africa is being eroded by HIV/AIDS. Much of the agricultural work in Africa is performed by women, especially in the case of subsistence farming. However, the arduous nature of agricultural work involves long hours of work with few rest breaks, lifting and carrying heavy loads, prolonged bending and stooping, exposure to extreme temperatures and various weather conditions, including sun, wind and rain, and biological and chemical agents damaging to health. Imagine attempting to perform this work as the sole source of income for a household of several children while one is symptomatic with HIV. No wonder the ILO reports women working on large-scale farms in Zimbabwe have shown the highest rates of illness. Many do not seek health care for fear of losing their jobs. Moreover, women involved in seasonal work generally report to male supervisors, who can sexually harass them through lack of hiring or withhold payment for work unless they offer 'sexual favours' (ILO economic security report, 2004:170). In an ILO survey conducted in Tanzania, 19 per cent of the women employed in the informal sector reported often suffering sexual harassment. In all probability resulting from the country's HIV/AIDS epidemic and perhaps related to the previous statistic, the ILO also reported nearly two in every five households in Tanzania having insufficient income to pay for common health care needs (ILO economic security report, 2004:179).

Elderly women in particular are bearing an extraordinary burden emanating from the HIV/AIDS pandemic in sub-Saharan Africa. There are reports of grandmothers caring for generations of orphans, the children of sometimes several of their own children who have died of AIDS-related illness. In South Africa only 19 per cent of women reported they thought their economic position in old age would be good (ILO economic security report, 2004:95); HIV-related mortality, which may rise to as many as five million by 2011 and ten million by 2021, according to a recent report by Van Aardt (2004) will make this worse. If this survey were performed in Swaziland or Zimbabwe, it undoubtedly would result in an even lower percentage. That such a low percentage of women in South Africa, the economic powerhouse of the whole continent, believes their economic future looks positive is tragic.

The impact of HIV/AIDS on food security in Southern Africa

A systematic erosion of the productive capacity of whole communities stemming from the HIV/AIDS pandemic is being witnessed in sub-Saharan Africa (ILO economic security report, 2004:126). Southern Africa's food crisis in 2002-2003, when at least 14 million people were deemed food-insecure and needed food assistance, was an explicit manifestation of the growing impact of the HIV/AIDS pandemic in the subregion, combined with other long-standing vulnerabilities. As the UN agency prepared to launch a full-fledged response in July 2002, the World Food Programme's (WFP) executive director James Morris explained, 'The combination of widespread hunger, chronic poverty and the HIV/AIDS pandemic is devastating and may soon lead to a catastrophe. Policy failures and mismanagement have only exacerbated an already serious situation' (UNAIDS, 2004:46).

The impact of the HIV/AIDS pandemic results in fewer agricultural workers, less food brought to market, less food availability, the loss of indigenous knowledge, and a smaller range of crops grown. According to a report by South Africa's Human Sciences Research Council (HSRC), 'All dimensions of food security – availability, stability, access and use of food – are affected where the prevalence of HIV/AIDS is high' (De Klerk, *et al.*, 2004:16). The problem here is that people living with HIV/AIDS have greater nutritional requirements based on their declining immune systems. Thus it is critically important for them to receive proper nourishment.

According to the Famine Early Warning Systems Network (FEWS NET), critical food shortages will also occur during the 2004-2005 consumption period in Southern Africa. While assessments in 2004 showed improvements in agricultural production in two of the six countries affected by the food crisis in 2002-2003, Angola and Mozambique, they also indicated that higher production deficits will occur in Lesotho, Malawi, Swaziland and Zimbabwe. Thus the crisis, more or less, continues. The government of Zimbabwe stopped the WFP's food assessment being conducted there in May. Consequently, Zimbabwe will be an 'uncovered gap' amidst the crisis situation in the coming year, according to FEWS NET, which is likely to result in even greater socio-economic deprivation in that country than seen to date.¹¹

¹¹ FEWS NET, 15 August 2004. Southern Africa food security brief.

Also alarmingly for the subregion as a whole, a report released by the HSRC in January 2004 stated that 14 million South Africans, or about 35 per cent of the population, were vulnerable to food insecurity (De Klerk, *et al.*, 2004:16). South Africa has been the producer of a substantial amount of donor food distributed in response to the present food crisis. If the country is unable to meet its own needs in the future, it is possible food security across the whole subregion will become a much greater challenge. Consequently, at the same time that millions of people need more food and more nutritious food than ever not only to subsist but to survive, the present and future food security of at least six of the 16 Southern African countries is under threat. Given the subregion's average adult HIV prevalence rate of 17.9 per cent, and worsening epidemics in some countries, food insecurity in Southern Africa most likely will grow.

The impact of HIV/AIDS in Southern Africa on orphans

Orphans are among the most vulnerable human beings in society, and in Southern Africa, there were nearly six million 'orphans due to AIDS' at the end of 2003 (UNAIDS, 2004:193). UNAIDS estimates by 2010 South Africa alone might be home to more than three million orphans, 18 per cent of all the children in the country, or nearly one in five (UNAIDS, 2004:61). Research conducted in Malawi showed young children whose mothers died were 3.3 times more likely to die themselves. A study in Zimbabwe found 65 per cent of households dissolved after the death of the adult female head of household, putting the health, development, security and safety of all the children at risk in the future (Webb & D'Allesandro, 2004:21). A study conducted in South Africa in 2002 found that the major health impact on orphans and vulnerable children as expressed by these children, was malnutrition (Giese, *et al.*, 2003:xx). The children themselves described their greatest need as food, which emphasises both the food crisis in Southern Africa and the growing importance of food security across the subregion in the future.

Studies from Botswana, Lesotho and Zambia show girls are taken out of school to care for one or both parents who are ill from HIV/AIDS (UN, 2004:10), highlighting their educational deprivation before they become orphans. Indeed, it has been extensively documented that girls more often become the family caregivers. Yet ironically in Botswana, Lesotho, Namibia and South Africa, secondary school enrolment among girls is higher than for boys. Thus advances made in gender equity with regard to education are declining as more and more people are becoming ill with AIDS-related disease. For girls who become orphans, their likelihood of becoming impoverished will

increase; and the occurrence already observed in Southern Africa over the past decade of girls involving themselves in the 'sugar daddy' syndrome will become even more common. Based on impoverishment and seeking a better life, young girls engage in transactional sex for money, goods or basic services, mostly with older men, greatly heightening their risk of HIV infection. Orphaned girls have more reason than most to seek to better their situation economically. Research in Zimbabwe documented two out of every three young women aged 17 to 24 reporting their most recent sexual partners were at least five years older. Strikingly, a Zambian study noted 18 per cent of girls tested positive for HIV within a year of losing their virginity (UN, 2004:13). For girls who are orphans, practicing unsafe sex will continue to fuel the HIV/AIDS epidemics and at the same time will potentially dramatically shorten their own life-spans. Yet these girls are only trying to survive.

Orphaned boys in some countries in Southern Africa also face potentially deadly choices just trying to survive, beyond the threat of HIV infection. 'If you do not have a birth certificate, or if you do not have a family or community to protect you, you are very vulnerable. There is a very high risk that these children will join armed groups because they offer children who are looking for protection both food and some kind of group environment,' reported the senior co-ordinator for refugee children at the UN Office of the High Commissioner for Refugees in March 2004.¹² In the DRC in September 2004, the WFP is covering the food needs of 300 000 child soldiers in training centres, to support the government's stated commitment to demobilise them.¹³ While this situation may seem an overly dramatic description of Southern Africa, the refugee situation is growing in the subregion, and HIV/AIDS is having an impact on food security and security in general. One recent survey estimated nearly 3.5 million Zimbabweans now live outside the country, more than a quarter of its previously estimated population (Ndlovu, 2004:224). Anecdotal reports cite a growing number of street children in some parts of South Africa, including KwaZulu-Natal province, where HIV prevalence rates are considered to be the highest in the country.

It is important to recognise that the impact of orphanhood does not start only when a parent dies. Children in AIDS-affected households experience severe psychological consequences even before they become orphans (Webb & D'Allesandro, 2004:9). According to the research

¹² Irin News, 11 March 2004. DRC: interview with Christin Linner, UNHCR Senior Coordinator for Refugee Children. Kinshasa: Irinnews. UN Office for the Coordination of Humanitarian Affairs. <http://www.plusnews.org/print.asp?ReportID=39983>.

¹³ World Food Programme, 22 September 2004. World hunger - Congo, DRC. Rome: World Food Programme. http://www.wfp.org/country_brief/indexcountry.asp?country=180.

by Giese, *et al.* in South Africa in 2002, the situation orphans face is similar to what other extremely impoverished children face, but for orphans the conditions are exacerbated because there is no real safety net into which they can fall and bounce back. The HIV/AIDS epidemic is amplifying the social patterns already in existence. However, orphans now number too many for South Africa's social policies and legal systems to be enforced on their behalf, as social workers in South Africa are overwhelmed by the number of cases (Giese, *et al.*, 2004:xiii, xvii). Clearly, the growing number of orphans and vulnerable children in Southern Africa is already beyond the 'carrying capacity' of the subregion, yet their numbers are predicted to grow dramatically in coming years – unless there is an alacritous, extensive and successful roll-out of HIV/AIDS treatment.

The impact of HIV/AIDS on economic growth in Southern Africa

One of the previous conundrums of the HIV/AIDS pandemic was that macroeconomic figures were not capturing the impact of HIV/AIDS despite its visibility in some especially hard-hit areas of East and Southern Africa, and with the inclusion of anecdotal evidence. That situation is changing. The ILO's *HIV/AIDS and Work: Global Estimates, Impact and Response 2004* report includes data demonstrating the economic impact in Southern African countries resulting from their HIV/AIDS epidemics (see Table 5).

TABLE 5: ESTIMATED IMPACT OF HIV/AIDS ON ECONOMIC GROWTH IN SOUTHERN AFRICA 1992-2002

COUNTRY	ESTIMATED AVERAGE ANNUAL RATE OF GROWTH OF GDP LOSS ATTRIBUTABLE TO HIV/AIDS (%)	ESTIMATED AVERAGE ANNUAL RATE OF GROWTH OF GDP PER CAPITA LOSS ATTRIBUTABLE TO HIV/AIDS (%)	ESTIMATED AVERAGE ANNUAL GDP LOSS ATTRIBUTABLE TO HIV/AIDS (US\$ MILLIONS)	ESTIMATED AVERAGE ANNUAL GDP PER CAPITA LOSS ATTRIBUTABLE TO HIV/AIDS (US\$)
Angola	0.6%	0.4%	97	7
Botswana	2.8%	1.8%	270	105
Dem. Rep. of the Congo	0.7%	0.4%	213	3
Lesotho	2.4%	1.6%	107	28
Malawi	1.7%	1.0%	83	5
Mozambique	1.5%	1.0%	192	7
Namibia	2.1%	1.3%	196	71
South Africa	2.1%	1.3%	7,230	115
Swaziland	2.8%	1.8%	177	71
Tanzania	1.2%	0.8%	177	4
Zambia	1.8%	1.1%	127	9
Zimbabwe	2.3%	1.4%	638	35

Data source: International Labour Office: *HIV/AIDS and Work: Global Estimates, Impact and Response*

According to the UNFPA in its 2004 report on the world population, 'Studies show that if 15 per cent of a country's population is HIV-positive, its GDP will decline by 1 per cent per year' (UNFPA, 2004:4). However, the ILO's 2004 report using macroeconomic data from 2002 shows the impact of the HIV/AIDS epidemic in seven of 12 countries in Southern Africa was greater than one per cent from 1992 to 2002 in the loss of GDP growth (ILO HIV/AIDS and work report, 2004:76), being nearly three per cent (2.8 per cent) in both Botswana and Swaziland. The loss per capita in these two countries over the ten-year period was nearly two per cent (1.8 per cent). In South Africa, the estimated average annual loss because of the country's HIV/AIDS epidemic was US \$7 230 million, or more than US \$7 billion, from 1992 to 2002, with a GDP per capita loss of US \$115 annually. In Botswana the GDP per capita loss in the period was US \$105, in Swaziland

it was US\$71, and in socio-economically taut Zimbabwe the GDP per capita loss was US\$35. That amount per person to a family of seven in acutely economically depressed Zimbabwe could go a long way towards feeding them or paying for essential medicines.

Given the latest figures, no one can honestly claim the HIV/AIDS pandemic is not having an extensive impact on Southern Africa, exacerbating its previous problems. While statisticians differ over base population numbers, estimates, fertility rates, and even mortality figures, food security remains a serious and potentially growing challenge; the number of orphans is increasing; and the already inferior economic position of women appears to be weakening in countries in the subregion. This is a 'state of emergency.' Not only is the HIV/AIDS pandemic killing millions of people, it is impoverishing Southern Africa, a subregion still offering a vast array of natural resources. It is time to prioritise Southern Africa's human resources, its greatest asset and the one most vulnerable to the subregion's HIV/AIDS crisis – and ultimately the most limited.

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