international UPDATE 10/94

THE AIDS EPIDEMIC IN SOUTHERN AFRICA GAINS MOMENTUM

Dr. Alan Whiteside is the Senior Research Fellow in the Economic Research Unit at the University of Natal (Durban). Readers will be interested to learn that his unit has just been awarded a contract to carry out a study of the impact of the HIV epidemic on the social and economic development of certain developing countries in Africa. The project has already been funded to the extent of R1,800,000. An award of this size only serves to reinforce the conclusions offered by Dr. Whiteside's paper.

AIDS took some time to reach Southern Africa. It seemed, to many people, to be confined to the countries of Central Africa and the homosexual population of the west. The fact that, in South Africa up to 1990, most of the AIDS cases were in the gay community only served to confirm this prejudice. The reality was that while the numbers of AIDS cases were small the Human Immunodeficiency Virus (HIV) was spreading in the population. Today the region is on the brink of a devastating epidemic.

HIV SURVEY DATA

At the end of March 1994 the South African Department of national Health and Population Development released the results of the fourth national HIV survey amongst women attending antenatal clinics in South Africa. The survey was carried out in October/November 1993, and 12,360 specimens from around the country were tested. The survey was virtually ignored by the media. This was a great pity, as the data show that HIV continues to spread and represents a serious threat to the future of the country economically, socially and politically.

The survey provides the best data in sub-Saharan Africa, and among the best in the world. It is significant for a number of reasons:

* As it was the fourth survey we now have a good series of data.
* The sample size has been constant and is statistically valid.
* The survey has been carried out at the same time each year.

The highest levels of infection are in KwaZulu/Natal, and this has been the case throughout the epidemic. Levels are low in the rural areas, especially in the Cape and parts of the Transvaal. The apparent decline in Lebowa is probably due to a small sample size or problems with sampling, Apparent low levels are no cause for comfort, as the Natal data shows. The high levels of rural urban interchange and movement, the violence, and poverty mean that there is the potential for HIV to spread rapidly.

The results of the past four surveys are shown on Table 1. The steady increase in HIV levels is as predicted, and means there has been little behaviour change. What is of even greater concern is that there is no sign of the epidemic slowing down. Directorate of Epidemiology noted that the doubling time of HIV infection is 12.05 months, by October/November 1994 about 8% of antenatal clinic attenders will be infected, perhaps 7% of adult South Africans.

Jan Smuts House
University of the Witwatersrand
Braamfontein Johannesburg
South Africa
Telex: 4-27291 SA

P.O. Box 31596
Braamfontein
2017
Tel: (011) 339-2021
Fax: (011) 339-2154

TABLE 1: Results of Four South African National HIV Surveys (%)

Region	1990	1991	1992	1993
Cape	0.16	0.37	0.66	1.33
KwaZulu Natal	1.91	2.87	4.**	9.62
OFS (incl. QwaQwa)	0.58	1.49	2.87	4.13
Transvaal (incl. Nat.states)	0.53	1.11	2.16	3.09
Transvaal (excl. Nat.states)			2.56	4.05
Gazankulu	0.0	0.0	1.58	2.61
KaNgwane	0.0	1.71	3.25	3.62
KwaNdebele	0.0	0.70	1.10	1.22
Lebowa	0.0	0.55	1.10	0.55
Qwaqwa	0.0	0.94	1.20	2.48
Transkei	0.0	3.49	0.83	1.54
Venda	0.0	0.54	0.64	1.45
All South Africa	0.7*	1.15	2.42	4.25

* TBVC excluded from 1990 survey.
SOURCE: DNHPD, Epidemiology, 30 March 1994

The data are also collected by population group and age. These are shown on Tables 2 and 3. It is not surprising to find the highest levels of HIV infection in the black population. This group is the poorest and least accessible. The apparent fall in the Asian community is indicative of small samples, in all other groups the rates are rising.

TABLE 2: HIV by Population Group in South Africa (%)

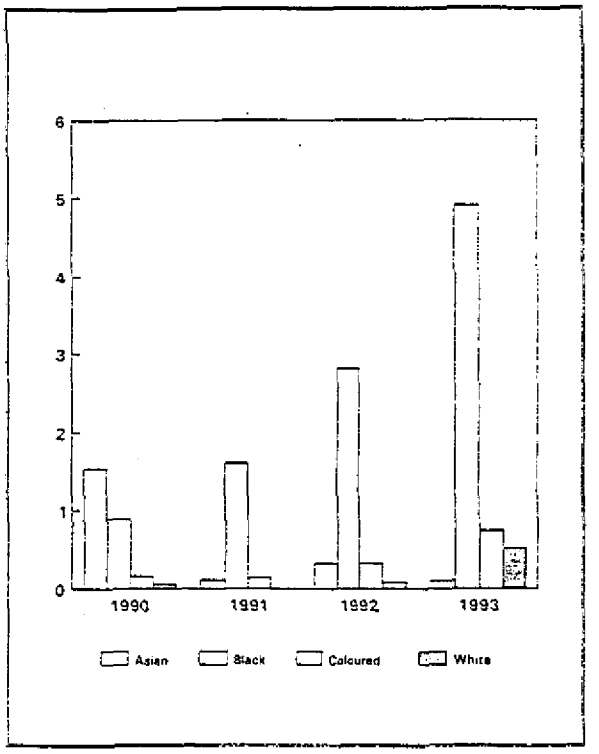
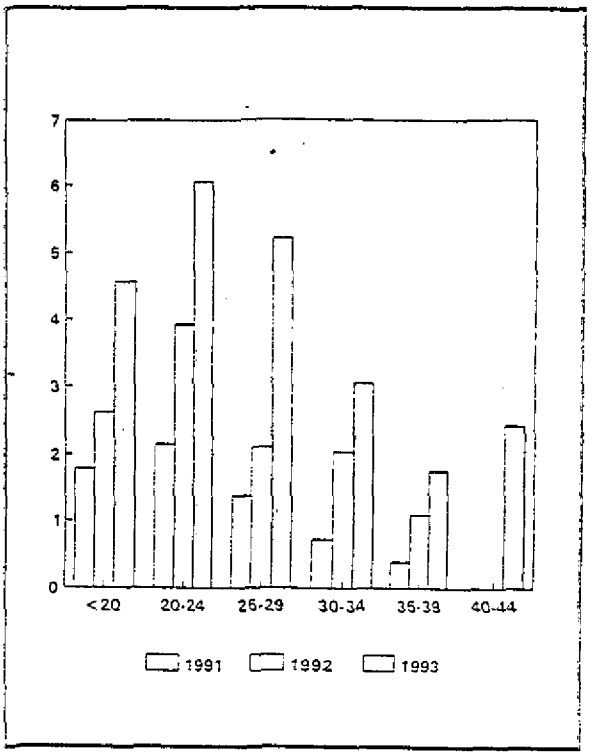


TABLE 3: HIV by Age Group in South Africa (%)



The data on HIV infection by age group are particularly worrying. The levels among the under 20s mean that many of the next generation are already infected. If there is one group that needs targeting it is the youth. The highest level is in the 20-24 age group closely followed by 25-29. They constitute the working population and the future of this group is bleak.

The situation in South Africa's neighbours gives further cause for concern. Data collection in Zimbabwe and Mozambique has been hampered by a shortage of test kits, and in the case of Mozambique, lack of access to parts of the country. There are, however, good data from Swaziland and Botswana. The Swaziland antenatal survey results are shown in Table 4 while those of Botswana are illustrated in Table 5.

TABLE 4: HIV in Swaziland: Antenatal Clinic Surveillance Results

Region	% Positive - 1992	% Positive - 1993
Hhohho	4.3	17.2
Manzini	4.1	22.9
Shiselweni	4.2	20.1

SOURCE: National AIDS Prevention and Control Programme

TABLE 5: HIV in Botswana: Antenatal Data, Selected Sites

Site	% Positive - 1992	% Positive - 1993
Gaborone	14.9	19.2
Francistown	23.7	24.2
Lobatse		17.8
Chobe/Kasane		18.3

SOURCE: National AIDS Control Programme

AIDS CASES DATA

These are the visible face of the epidemic. They are, however, very under-reported. It is estimated that in Africa only some 20% of cases get reported. Furthermore, given the long incubation period of the disease, AIDS cases reflect the HIV levels in the population of some five to eight years previously. The reported cases in the region are shown on Table 6.

TABLE 6 AIDS Cases in Southern Africa

Country	Cases	Rate per million pop.	Date of Report
Angola	608	64	May 1993
Botswana	1415	1010	December 1993
Lesotho	479	252	December 1993
Malawi	31857	3185	December 1993
Mozambique	826	54	December 1993
Namibia	5101	3188	December 1993
South Africa	3210	82	April 1994
Swaziland	413	516	February 1994
Tanzania	38791	1292	January 1993
Zambia	29734	3457	October 1993
Zimbabwe	25332	2367	September 1993

SOURCE: Swaziland - National AIDS Prevention and Control.
Programme Data provided to author.
South Africa - Epidemiological Comments Vol.21(4), April 1994.
All other - Panos Institute, World AIDS Database, July 1994.

PROSPECTS FOR THE EPIDEMIC

In the past, when new diseases have appeared and begun to spread, the scientific and medical community has reacted in a technocratic manner. Very often they have been able to halt or cure the diseases in this manner. AIDS is different and it is important to recognise that, at present, there is little likelihood of either a cure or a vaccine before the end of the century. Even then it is by no means certain that this would be affordable in the developing countries, where, of course, it is most needed.

The data shows that HIV continues to spread unchecked in South Africa. This is deeply worrying as it could put at risk all the social, political and economic gains we expect the new government to make over the next few years. The spread of HIV is a harbinger of an increase in AIDS cases. It foreshadows an inevitable increase in illness and death in five or six years. The epidemic of AIDS cases is gaining momentum, and in 1994 there will already be 8000 new cases of AIDS in South Africa.

What are the chances of stopping the spread of the virus? The figures from the region show that there has been little success in doing this so far. It is true that in South Africa the government has, up to now, allocated little to the problem. In 1993 only R21 million was available. This has changed with the election of the Government of National Unity. Dr. Zuma, the new Minister of Health, has asked for R256 million for the National AIDS Implementation Plan, and will probably get it. The money will be spent largely (53%) on prevention of transmission, especially sexual transmission; and reducing the personal and social impact of HIV infection (38%).

The regional spread of the proposed funding reflects the epidemic. KwaZulu/Natal should receive over R50 million, 20% of the money; the PWV will get R31.7 million; and R71 million will be spent nationally.

Having the resources will help, but it is not enough. There are two questions that must arise. Firstly, is there the capacity to spend this money? There is a very real fear that much of it will be wasted on pointless research, fruitless education campaigns and jobs for the boys. Secondly, is the government the best organisation to stop the epidemic? Experience around the world has shown that governments lack credibility and efficiency. The most successful campaigns have been in the workplace and those run by non-governmental organisations.

THE IMPLICATIONS OF THE EPIDEMIC

In order to understand the implications of the epidemic we only need to look at countries to the north. For example, in Zambia one of the banks recorded a rise in mortality among staff from 0.4% per annum to 2.2% per annum in 1992. It is now virtually impossible to buy life insurance in a number of countries, and no lesser authority than the World Bank has warned that GDP growth will be reduced. South Africa, with its relatively sophisticated economy, and shortage of skilled and experienced manpower, may be worse affected than other countries.

In South Africa the implications are simple. Over the next few years there will be a growing number of AIDS cases presenting at the hospitals and health facilities around the country. They will be in addition to the existing case loads. The resources will have to be found to care for these patients. This will require some imaginative schemes in order to provide cost-effective care.

The increase in morbidity and mortality will also affect the running of the national economy. Losing skilled manpower will be disastrous, but is inevitable. There is also likely to be an impact on the insurance industry and hence the funds available for investment. There will be a considerable increase in the number of orphans and schooling will suffer.

Now that the political dust has settled we can only hope that the AIDS epidemic will receive the attention it deserves. In the long run, peace and economic development will address many of the causes of its spread. Unfortunately it is the short run that needs attention. At best, the AIDS epidemic should be seen as a national emergency, and at least, a national priority. There are two things that must be done: firstly prevention efforts must be stepped up and the business sector and political leadership must become more involved; secondly we must begin to plan for the inevitable increase in cases.

Five years ago people were sceptical of the projections of the epidemic. These projections were largely correct, as is being shown by both the HIV surveys and reported AIDS cases. The predictions of the social and economic implications may also come true unless there is a measured and immediate response.

STATEMENT OF PURPOSE

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