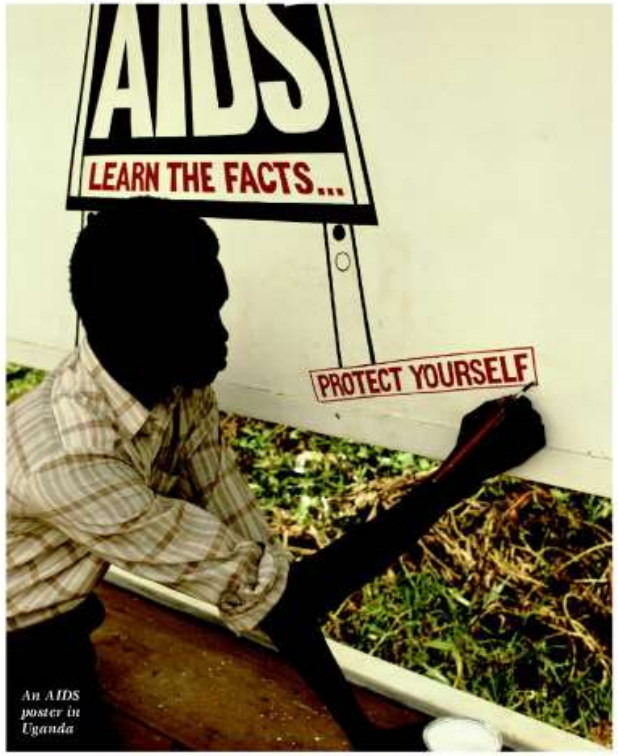
HIV/AIDS in sub-Saharan Africa

Alexander Cooke

HIV/AIDS is an infectious disease particularly prevalent in eastern and southern Africa. You need to know about it for topics on health issues, pollution and human health at risk, and development. This article describes the impacts of the disease and uses two contrasting case studies to show the effects it can have and ways in which governments can combat the disease.



An AIDS poster in Uganda

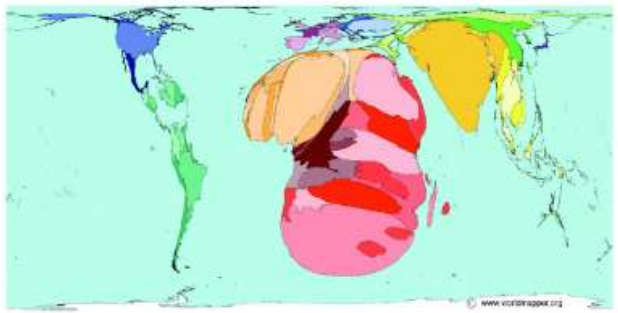


Figure 1 The global prevalence of HIV, according to Worldmapper

Two-thirds of people living with HIV are in sub-Saharan Africa, according to the Joint United Nations Programme on HIV/AIDS, although this region contains little more than 10% of the world's population (Table 1 and Figure 1). Looking at the breakdown of new infections (Figure 2), this African crisis seems likely to worsen.

The impacts of the disease

Sub-Saharan Africa accounted for 67% of all HIV cases and 75% of the global death toll from AIDS in 2008, according to the UNAIDS Global Report. The UN estimates that between 33 and 36 million people in the world are infected with HIV/AIDS: a major **pandemic**. In many countries of sub-Saharan Africa the disease plays a central part in holding back socioeconomic development.

Figure 3 shows that there is a dramatic concentration of AIDS in the southern part of the continent. In some countries the adult population is living with tragically high rates of HIV infection: Swaziland (26%), Botswana (24%), Lesotho (23%), South Africa (18%), Namibia (15%), Zimbabwe (15%). Note that Uganda has a relatively low rate (5%), which indicates success in managing the disease.

The most obvious effect of this crisis has been illness and death, with a strain on health services, but the impact of a disease that affects mainly adults of working age is huge: households, schools, workplaces and economies have also been badly affected. The stigma of HIV infection is still apparent in many sub-Saharan African nations, particularly in isolated rural places.

Figure 4 shows that the disease is a pandemic, although the rate of new infections has slowed. Western countries, despite their superior economies, medical facilities and staff available to manage the problem, are still finding HIV prevalence a major challenge. We can speculate about the reasons for this, but they must be linked to social values and attitudes. Until recently HIV/AIDS has not been widely covered in the education curriculum and we live in a hedonistic society, where sex, drugs and alcohol are readily available.

inset 1 Key terms in understanding the spread of HIV/AIDS

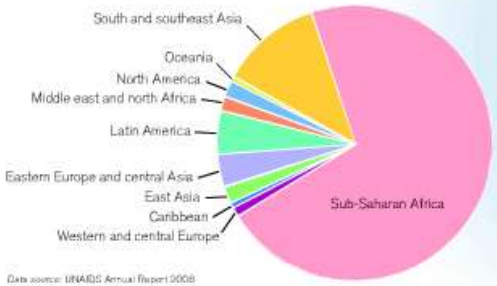
Anti-retroviral (ARV) Anti-retrovirals are drugs used to slow the development of HIV into AIDS, allowing the patient to live much longer and possibly pass on their knowledge to future generations.

Attack rate The number of newly infected people in a given area in a given time period (e.g. 1 year).

Fatalism The idea that people are powerless to change what will happen.

Pandemic A spreading disease affecting the global population, although some regions will be prone to higher prevalence and attack rates than others.

Prevalence rate The number of people currently living with the disease in a given area.



Data source: UNAIDS Annual Report 2008

Figure 2 New HIV infections, 2007 (2.7 million)

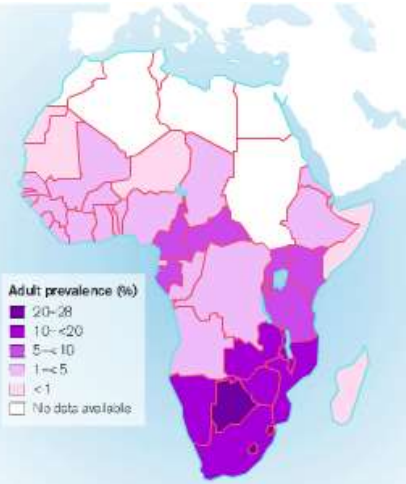


Figure 3 The adult prevalence of HIV in Africa, 2007

Table 1 Regional statistics for HIV/AIDS, 2007

Region	People living with HIV/AIDS	Adult prevalence (%)*	Deaths
Sub-Saharan Africa	22.0 million	5.0	1.5 million
North Africa and middle east	380,000	0.3	27,000
Asia	5 million	0.3	380,000
Oceania	74,000	0.4	1,000
Latin America	1.7 million	0.5	63,000
Caribbean	230,000	1.1	14,000
Eastern Europe and central Asia	1.5 million	0.8	58,000
North America, western and central Europe	2.0 million	0.4	31,000
Global total	33.0 million	0.8	2.0 million

*Proportion of adults aged 15–49 who were living with HIV/AIDS
Source: http://www.avert.org/worldstats.htm

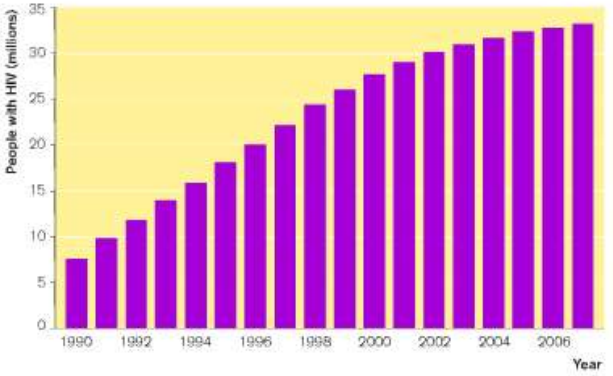


Figure 4 The number of people in the world living with HIV, 1990–2007

Case study: Lake Victoria, Kenya

According to the UN, the few patients who are able to make the journey to the hospital in Bondo (the main town in this area) mostly come from the beaches or islands of Lake Victoria (Figure 5). They tend to be fishermen at the top of a hierarchical economy around Lake Victoria, who can afford the transport to get to Bondo. Around 70% of them test positive. In this area the majority of children and young adults are AIDS orphans and possibly HIV sufferers themselves. Many leave education to look after their sick relatives and they all suffer from the stigma associated with HIV.

Lake Victoria is home to one of Africa's biggest fishing industries. It is an industry that links many different members of society. Fishermen supply the markets in the town of Bondo and surrounding villages. The market stalls are run by women, sometimes teenage girls. Competition between market traders is high. The money to buy food and ARV drugs for relatives, including parents, depends on their success. These women are pressed into offering sexual favours to fisherman, male transporters and market owners in the upper hierarchy of what is termed the 'Jaboya System'. This is the sexual power system between fishermen, traders and women who buy the fish for food or to sell at market.

Figure 5 Map of east Africa

If men or women become infected with HIV/AIDS they are often reluctant to tell partners that they are HIV positive because of the stigma attached to the disease. They may not even be aware that they are infected. The fishermen follow the migrating fish in Lake Victoria, spreading the disease through the communities around the lake, including those in Uganda and Tanzania. According to the UN, Ndeda Island is one of the worst hit communities. From a 1997 population of 6,000 only 2,400 remain. The impact of the disease is catastrophic.

Case study: Uganda

The approach to preventing HIV/AIDS in Uganda is called ABC:

- sexual abstinence until marriage
- be faithful to a single partner or reduce the number of partners
- always use a condom

Men returning from a night's fishing on Lake Victoria are surrounded by people jostling to buy their catch

inset 2

Uganda's HIV/AIDS policies, 1985–2001

1986 President Yoweri Museveni responded to the emerging HIV crisis in Uganda swiftly, embarking on a nationwide tour to promote the ABC policy. The first AIDS control programme was established, focusing on providing safe blood products, and educating people about risks.

1990 The AIDS Information Centre was formed to provide voluntary counselling and testing.

1994 AIDS Control Program Units established. $50 million borrowed from the World Bank to fight the epidemic. The Ugandan government and other donors made this up to a total of $75 million to set up the Sexually Transmitted Infections Project.

2000 The government began to 'mainstream' HIV/AIDS issues in Uganda's Poverty Eradication Action Plan. The need to address the underlying socioeconomic conditions that accelerate the spread of HIV/AIDS was recognised.

2001 The World Bank agreed to spend $47.5 million over the next 5 years on Uganda's AIDS prevention and treatment programmes. According to UNAIDS estimates, national HIV prevalence had fallen to around 5% in 2001.

A number of strategies have encouraged people to follow this advice (Inset 2).

The message about HIV and AIDS has been effectively communicated to a diverse population by the government and by word of mouth. Very early in the course of the epidemic, the government recruited the Ugandan people to help themselves in the fight against HIV/AIDS. One of the first community-based organisations to be formed was The AIDS Support Organization (TASO). This was set up in 1987, when there was still a great deal of prejudice towards people with HIV.

Since 1986, when Uganda's health minister announced that there was HIV in the country, there has always been political openness about the epidemic, the risks, and how they might best be avoided. In that same year, the president toured the country, telling people that it was their patriotic duty to avoid contact with HIV. Money lent by the World Bank was pumped in to health promotion and education, providing free contraception and **anti-retroviral drugs** and funding support groups. AIDS prevalence in Uganda has steadily fallen (Figure 6).

The youth organisation Straight Talk produces radio shows and a newspaper for distribution in schools on a range of issues for young Ugandans. Feedback by this organisation suggests that teenagers are not abstaining from sex, but prefer to rely on condoms.

Figure 6 HIV prevalence in Uganda

Recent shortages of condoms have meant that the price in shops rose sharply – a major problem for poor families and communities. The shortage came about due to President Bush's administration reducing the supply of contraceptive aid to Uganda in response to the moral right wing in the USA. 'Because of the US, our government now says abstain and be faithful only. So people stop trusting our advice. They think we were lying about how condoms can stop AIDS. Confusion is deadly' (Dr Katamba, Uganda Protestant Medical Bureau, Avert).

In addition, in August 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria suspended the disbursal of mo from all five of Uganda's Global Fund gra after financial irregularities were disc ered within the Ministry of Health. Corr tion at high levels is not uncommon in African countries.

During the ongoing conflict in north Uganda, rebels have abducted thousand children. Conservative estimates place number of children taken by rebels minimum of 20,000. About 20% of the abducted are forced into 'marriages' given to senior commanders as rewards the escapees, about 50% have some typ sexually transmitted disease.

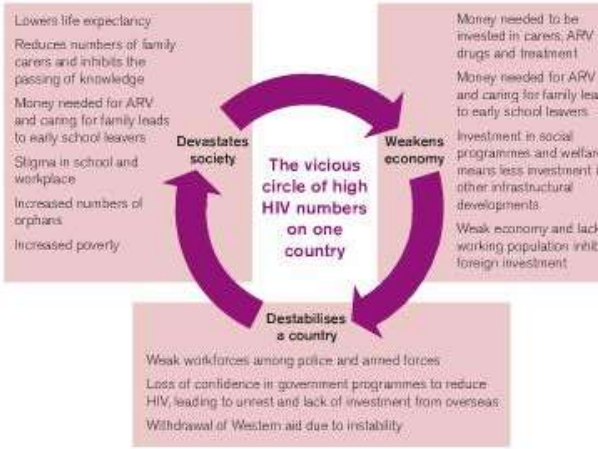


Figure 7

Conclusion

Figure 7 summarises the impact of HIV/AIDS in Africa. The disease has proved to be a potent social force, but the example of Uganda shows that government leadership can make a real difference.

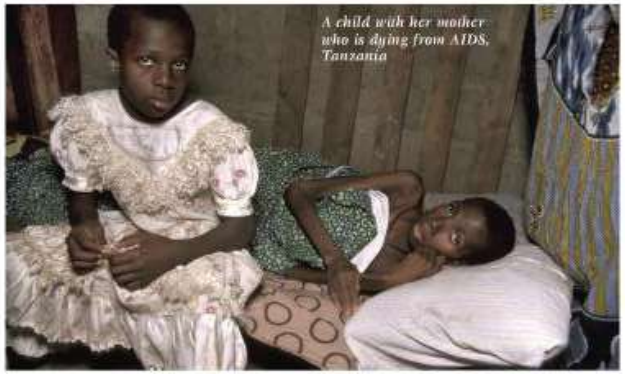
Questions for further discussion

(1) Goal 6 of the Millennium Development Goals is to combat HIV/AIDS, malaria and other diseases. Go to www.un.org/millenniumgoals/aids and read the targets. How do the case studies in this article compare with the general situation described here?

(2) You are Uganda's minister of health. What are your priorities for reducing the threat of HIV/AIDS?

(3) Should British aid provide free anti-retrovirals and condoms to Uganda?

(4) Why is HIV/AIDS having a negative economic affect on sub-Saharan African economies?



A child with her mother who is dying from AIDS, Tanzania

Further reading

Barrett, H. (2006) *Health and Development*, Routledge.

Sachs, J. D. (2005) *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, Earthscan.

Usdin, S. (2003) *No Nonsense Guide to HIV/AIDS*, New Internationalist.

www.unaids.org: the UN site.

www.who.int/countries for data on specific countries from the World Health Organization. It also has pages on HIV/AIDS

www.avert.org/aafrica.htm: an international HIV and AIDS charity, based in the UK.

A Weblinks document containing live links to these websites can be found on this issue of Geography Review Online.

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Key points

- The HIV/AIDS pandemic is most prevalent in sub-Saharan Africa.
- There are economic and social reasons why the disease is so widespread in certain African countries.
- The disease has catastrophic impacts on the society and economy of these countries.
- In Uganda a strong campaign by the government since the 1980s has reduced prevalence to about 5%, compared to 15–25% in southern Africa.

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