‘HIV and development challenges for Africa’

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Associate Director & Chief Scientific Adviser to UNAIDS

Session: Challenges of globalisation, regional integration and development of Africa
10th Anniversary of the Centre for the Study of Globalisation and Regionalisation Centre at Warwick University

Warwick, September 17, 2007
HIV and development challenges for Africa

• There is no one African epidemic: know your epidemic and act on it
• Upstream effects: structural drivers in Africa: poverty versus income equality: which is more powerful?
• Downstream impact: long wave impacts on poverty, GDP, human capital, social capital
• Responding to the interaction between HIV and poverty
Estimated number of people living with HIV and adult HIV prevalence

Global HIV epidemic, 1990–2005*

HIV epidemic in sub-Saharan Africa, 1985–2005*

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Even though the HIV prevalence rates have stabilized in sub-Saharan Africa, the actual number of people infected continues to grow because of population growth. Applying the same prevalence rate to a growing population will result in increasing numbers of people living with HIV.

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Percent of adults (15+) living with HIV who are female, 1990–2006

Figure 1

Percent Female (%)
HIV prevalence (%) in adults in Africa, 2005

**Adult prevalence %**

- 20.0 – 34.0%
- 10.0 – <20.0%
- 5.0 – <10.0%
- 1.0 – <5.0%
- <1.0%
HIV prevalence (%) by gender and urban/rural residence, selected sub-Saharan African countries, 2001–2005

15–49 years old, by gender

15–24 years old, by gender

15–49 years old, by urban/rural residence

Illustrative Results

Resources Needed for Prevention

Targets reached in 2010
Disconnect between dynamics of the epidemic and action: example from a West African country

- General population prevalence 1.8%; antenatal clinic data stable 10 years
- Peak age is 35-39 years (low prevalence in youth)
- **Sex worker** HIV prevalence 78% and 82% in 2 largest cities
- 75% of new infections in men in the capital city are **clients** of sex workers
- Strategic plan presupposes a highly generalised epidemic with widest possible engagement of society and a broad range of interventions
- Only **0.8% of AIDS investments** are focused on sex work
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HIV & Income Inequality - Africa

HIV Prevalence vs. GINI Coefficient

R² = 0.4881
p = 0.005%


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HIV prevalence & Life expectancy

at birth 2000

LE at birth (healthy years), total

GDP per capita in 1995 international dollars

size = HIV prevalence (age 15–49)

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Epidemic Curves, HIV, AIDS & Impact

HIV prevalence

AIDS - cumulative

SOCIAL AND ECONOMIC IMPACT

Numbers

A

B

T_1

T_2

Time
Impact of AIDS on life expectancy in five African countries 1970–2010


Lifetime risk of AIDS death for 15-year-old boys, assuming unchanged or halved risk of becoming infected with HIV, selected countries.

Source: Zaba B, 2000 (unpublished data)
Projected reduction in African agricultural labour force due to HIV and AIDS by 2020

Projected labor force loss (%) by year

Sources: ILO (2004). HIV/AIDS and work: global estimates, impact and responses
Human capital

- Rising morbidity & mortality leading to decreased productivity in public and private sector
- Investment declines at family, community, public sector and private sector levels
- Private sector: loss of skilled workforce, increased training needs, reduced management expertise
- Public sector: reduced tax revenues at a time of increased demand for health care and social support, reduced investment in child education, effects on workforce, potential for eroded governance capacity
- GDP effects: reduction of 0.5% to 1.5% in GDP growth rate over a 10 to 20 year period in high HIV prevalence countries
Between 1990 and 2003, sub-Saharan Africa’s population of children orphaned by AIDS increased from less than 1 million to more than 12 million.

Intergenerational effects

• Orphans: 13% less likely to attend school than non-orphans (maternal orphans, double orphans, girls)

• Orphans overwhelming capacity of social networks and traditional patterns of intergenerational dependency, creating an uneducated, unsocialized and uncared for generation

• Lost transmission of knowledge and skills between generations (cf Bell and Deverajan): cumulative weakening from generation to generation of human and social capital
People in sub-Saharan Africa on antiretroviral treatment as percentage of those in need, 2002–2005


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Women as a percentage of all adults receiving antiretroviral therapy in 30 countries: actual versus expected percentages, 2005

**Sub-Saharan Africa**
- Botswana
- Burundi
- Central African Republic
- Côte d'Ivoire
- Ethiopia
- Ghana
- Kenya
- Malawi
- Mozambique
- Namibia
- Nigeria
- Rwanda
- South Africa
- UR Tanzania
- Uganda
- Zambia
- Zimbabwe

**Latin America and Caribbean**
- Argentina
- Brazil
- El Salvador
- Guyana
- Haiti
- Honduras
- Panama
- Peru
- Venezuela

**Asia**
- Cambodia
- China
- India
- Viet Nam

*The expected percentage of women receiving ARV therapy is based on the percentage of people living with HIV/AIDS who are women.*


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Comparison of 2003 and 2005 data on the expansion of antiretroviral therapy and coverage of HIV-infected mothers who received antiretroviral prophylaxis in three sub-Saharan African countries

Coverage of antiretroviral therapy

Coverage of HIV-infected mothers who received antiretroviral prophylaxis

Sources: Individual country reports (2005).

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Impact of three scenarios on HIV infection in sub-Saharan Africa, 2003–2020

Impact of AIDS-related deaths in sub-Saharan Africa, 2003–2020

Source: Salomon JA et al. (2005). Integrating HIV prevention and treatment: from slogans to impact

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Targets and timelines

- **UNGASS young people HIV-infected**
  - 25% reduction in most affected countries 2005; 25% globally 2010

- **UNGASS MTCT: % HIV + infants born to HIV-infected mothers**
  - 20% reduction by 2005; 50% reduction by 2010

- **3 by 5 Initiative: 3 million on ART by end 2005**
  - Setting of next target?

- **US President's Emergency Plan 2008**
  - 2 million on treatment, 7 million infections prevented, 10 million people, including orphans, provided with care

- **Millennium Development Goals 2015**
  - Halt and begin to reverse the spread of HIV/AIDS

- **Global Fund rolling targets over 5 years (replenishment 2006, 2007)**
  - 1.6 million on treatment, 52 million reached by VCT; 1 million orphans
## AIDS funding requirements for low- and middle-income countries

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<tr>
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<td>0.6</td>
<td>0.9</td>
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<td>14.9</td>
<td>18.1</td>
<td>22.1</td>
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Sources of the estimated and projected funding for the AIDS response from 2005 to 2007*

* Assuming there are no new commitments

Impact of external grants on the macro-economy at country level

If small share in GDP, no problem
If grants used to purchase imports (e.g. drugs), not much of a problem—this is similar to receiving commodities
If grants used to purchase nontradeables (goods or services that you can’t import) then it creates demand for local goods and services; in large amounts, it pushes up their prices which disproportionately affects poor people

It also pushes up demand for local currency, *appreciating* the exchange rate which can have a potentially adverse effect on exporters.

Can you use grants to improve supply-side of economy—reduce key bottlenecks?

Adverse impact on revenue mobilization? Creates dependency?

Advantages of debt relief
Progress towards achieving the “Three Ones”: Percentage of countries with one national coordinating body, one national HIV/AIDS strategy or framework and one national monitoring and evaluation plan.

- National body: 85%
- National framework: 90%
- National monitoring and evaluation plan: 50%
Stakeholder participation in development of national AIDS plans in 79 countries, 2004

0% 20% 40% 60% 80% 100%

- UN agencies
- Civil society/NGOs
- People living with HIV
- Donors
- Line ministries
- Media
- District and local authorities
- Faith-based organizations
- Private sector
- Women’s groups

- full participation
- insufficient but increasing participation
- insufficient participation with no signs of improvement
- no participation

Source: (UNAIDS 2006) From advocacy to action: A progress report on UNAIDS at country-level, UNAIDS.
Addressing AIDS in the poorest communities and countries

- AIDS money has most impact when strategies are based on the concept of “know and act on your epidemic”.
- **Combine HIV programmes with poverty reduction initiatives.** e.g. NGOs integrating HIV prevention into village/community banking programmes/microfinance (Malawi) for women, and combine AIDS education with the provision of microfinance to groups of women: need to **shift from small-scale projects to large-scale programmes**.
- Provision of HIV treatment can help prevent poverty, delay orphaning – and indirectly contribute to HIV prevention as well.
- Development plans (whether they concern the development of productive sectors or the provision of social safety nets) must **“pass the AIDS test”**. e.g. World Bank-supported Chad/Cameroon Pipeline Project, supports HIV workplace interventions along the pipeline route - both for workers and for affected communities.
- Poverty reduction programmes and AIDS strategies must both **reduce vulnerability** - particularly of women and young people: protecting human rights and tackling issues around social marginalization and stigma.
- **Increased and sustained** international support, driven by high-level political commitment and anchored in country ownership.
Acknowledgements

• Peter Piot
• Michel Sidibe
• Robert Greener
• Efren Fadriquela
• Mihika Acharya
• Constance Kponvi
• YOU, THE AUDIENCE – THANK YOU!