HIV/AIDS Situation in Africa

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The HIV/AIDS pandemic marks a severe development crisis in Africa, which remains by far the worst affected region in the world. Forty-two million people now live with HIV/AIDS of which 29.4 million (70.0%) are from sub-Saharan Africa. Approximately 5 million new infections occurred in 2002 and 3.5 million (70.0%) of these were also from sub-Saharan Africa. The estimated number of children orphaned by AIDS living in the region is 11 million. In 2002, the epidemic claimed about 2.4 million lives in Africa, more than 70% of the 3.1 million deaths worldwide. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. HIV/AIDS stigma is still a major problem despite the extensive spread of the epidemic. A complex interaction of material, social, cultural and behavioural factors shape the nature, process and outcome of the epidemic in Africa. However, too many partners and unprotected sex appear to be at the core of the problem. Even if exceptionally effective prevention, treatment and care programmes take hold immediately, the scale of the crisis means that the human and socio-economic toll will remain significant for many generations. Although 70% of people living with HIV/AIDS are in Africa, only 6,569 (4.7%) of the 140,736 scientific publications on HIV/AIDS, from 1981 to 2000, are directly related to Africa. Effective responses to the epidemic require a multisectoral approach, including governments, the business sector and civil society.

Key words: HIV/AIDS, Africa

More than 20 years into the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pandemic, it has struck different regions, countries and populations in different ways. It especially marks a severe development crisis in sub-Saharan Africa, which remains by far the worst affected region in the world. The effect of AIDS in many African countries superseded that of war, drought, famine or any other prior emergencies in magnitude, duration, and challenge for programme response.

The presence of widespread poverty and underdevelopment in Africa exposes communities to all of the major environmental determinants of ill-health and this factor has contributed significantly to the rapid spread of HIV/AIDS. In 1999, the WHO estimated Disability Adjusted Life Expectancy (DALE) for 191 countries and the bottom ten countries were all in sub-Saharan Africa, where the HIV/AIDS epidemic is most prevalent, resulting in DALE at birth of less than 35 years. Years of healthy life lost due to disability represent 18% of total life expectancy in these bottom countries.

The trend in most African countries has been to ignore the calls for prevention of HIV/AIDS until the prevalence becomes unacceptably high. This is partly explained by the fact that the region also faces an acute lack of valid, reliable and comparable data, as well as processes for converting data into information for planning. Available data indicate that the pattern

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Table 1: Regional HIV/AIDS statistics as at end of 2002

<table>
<thead>
<tr>
<th>S/ No</th>
<th>Region</th>
<th>Year epidemic started</th>
<th>Adults &amp; children living with HIV/AIDS</th>
<th>Adults &amp; children newly infected with HIV</th>
<th>% prevalence among adults</th>
<th>% HIV positive adults who are women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sub-Saharan Africa</td>
<td>Late '70s/ Early '80s</td>
<td>29.4 million</td>
<td>3.5 million</td>
<td>8.8</td>
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<td>2</td>
<td>North Africa &amp; Middle East</td>
<td>Late '80s</td>
<td>550,000</td>
<td>83,000</td>
<td>0.3</td>
<td>55</td>
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<tr>
<td>3</td>
<td>South &amp; South East Asia</td>
<td>Late '80s</td>
<td>6.0 million</td>
<td>700,000</td>
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<td>36</td>
</tr>
<tr>
<td>4</td>
<td>East Asia &amp; Pacific</td>
<td>Late '80s</td>
<td>1.2 million</td>
<td>270,000</td>
<td>0.1</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>Latin America</td>
<td>Late '70s/ Early '80s</td>
<td>1.5 million</td>
<td>150,000</td>
<td>0.6</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>Caribbean</td>
<td>Late '70s/ Early '80s</td>
<td>440,000</td>
<td>60,000</td>
<td>2.4</td>
<td>50</td>
</tr>
<tr>
<td>7</td>
<td>East Europe &amp; Central Asia</td>
<td>Early '90s</td>
<td>1.2 million</td>
<td>250,000</td>
<td>0.6</td>
<td>27</td>
</tr>
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<td>Western Europe</td>
<td>Late '70s/ Early '80s</td>
<td>570,000</td>
<td>30,000</td>
<td>0.3</td>
<td>25</td>
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<td>North America</td>
<td>Late '70s/ Early '80s</td>
<td>980,000</td>
<td>45,000</td>
<td>0.6</td>
<td>20</td>
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<td>10</td>
<td>Australia &amp; New Zealand</td>
<td>Late '70s/ Early '80s</td>
<td>15,000</td>
<td>500</td>
<td>0.1</td>
<td>7</td>
</tr>
<tr>
<td>11</td>
<td>TOTAL</td>
<td></td>
<td>42 million</td>
<td>5 million</td>
<td>1.2</td>
<td>50</td>
</tr>
</tbody>
</table>


Table 2: Global summary of the HIV/AIDS epidemic as at December, 2002

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of people living with HIV/AIDS</th>
<th>Population affected with HIV in 2002</th>
<th>AIDS deaths in 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adults</td>
<td>38.6 million</td>
<td>4.2 million</td>
<td>2.5 million</td>
</tr>
<tr>
<td>2 Women</td>
<td>19.2 million</td>
<td>2.0 million</td>
<td>1.2 million</td>
</tr>
<tr>
<td>3 Children under 15 years</td>
<td>32.0 million</td>
<td>800,000</td>
<td>610,000</td>
</tr>
<tr>
<td>Total</td>
<td>42.0 million</td>
<td>5.0 million</td>
<td>3.1 million</td>
</tr>
</tbody>
</table>


Figure 1. Adults and children estimated to be living with HIV/AIDS as of end 2002. *Source: UNAIDS (2002)6.*

Figure 2. Estimated number of adults and children newly infected with HIV during 2002. *Source: UNAIDS (2002)6.*

of HIV/AIDS in developing countries, particularly sub-Saharan Africa, is unique; the epidemic is mainly heterosexual, the rates of infection in the general population are very high and the percentage of HIV-positive women is greater than men. An additional feature is the young age of onset of infection for women.

Infections acquired in Africa and among Africans are making an increasing contribution to HIV infection in other continents. In the United Kingdom, of all reported HIV infections diagnosed by the end of 2001, 21% (9,993 of 48,226) were probably acquired in Africa. Also 23% (4,883 of 21,291) of those living with diagnosed HIV infection in 2000 were described as black African, 81% of whom lived in London.

Prevalence of HIV/AIDS in the African region

Forty-two million people now live with HIV/AIDS of which 29.4 million (70.0%) are from sub-Saharan Africa (Tables 1 and 2, Figures 1 and 2). Approximately 5 million new infections occurred in 2002 and 3.5 million (70.0%) of these were also from sub-Saharan Africa (Table 1). Fewer than 30,000 people were estimated to have been benefiting from antiretroviral drugs at the end of 2001. The estimated number of children orphaned by AIDS living in the region is 11 million. Even if exceptionally effective prevention, treatment and care programmes take hold immediately, the scale of the crisis means that the human and socio-economic toll will remain significant for many generations.

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According to the UNAIDS, the HIV/AIDS epidemic is at an early stage of development and despite the manifest potential for explosive growth within a matter of years, its overall dynamic needs to be considered in a time frame of decades. At the current rate of infection, there could be 45 million new cases of HIV by 2010. In any country where 15% of adults are now infected, at least 35% of those who are currently teenagers will eventually die of AIDS. According to the Joint UN Programme on HIV/AIDS report, AIDS will cause early death in as many as half of the teenagers living in southern Africa. In Botswana, demographers have predicted that two-thirds of the 15-year-olds will die of AIDS before the age of 50.

In southern Africa (where the epidemic is the most severe in the world), HIV rates are still on the rise, with HIV infections occurring among more than 40% of all pregnant women, in some locations. Southern African countries had been hopeful that the epidemic may have reached its ‘natural limit’, beyond which it would not grow. Thus, it has been assumed that the very high HIV prevalence rates in some countries have reached a plateau. Unfortunately, this appears not to be the case, as yet. In Botswana, median HIV prevalence among pregnant women in urban areas already stood at 38.5% in 1997. In 2001, it had risen to 44.9%. Similar patterns are visible elsewhere. In Zimbabwe, HIV prevalence among pregnant women climbed from 29% in 1997 to 35% in 2000, while in Namibia it rose from 26% in 1998 to 29.6% in 2000, and in Swaziland from 30.3% to 32.3%, in the same period. If a natural HIV prevalence limit does exist in these countries, it is considerably higher than previously thought.

Startling as these prevalence levels are, they do not reflect the actual risk of acquiring HIV, and prevalence rates are even higher in specific age groups. In Botswana, among 25–29-year-old women attending antenatal care in urban areas, 55.6% were living with HIV/AIDS in 2001. In Swaziland, the corresponding prevalence rate in 2000 was 33.9%, and in Zimbabwe it was 40.1%. According to the South African Ministry of Health, HIV prevalence among pregnant women attending antenatal clinics reached 24.8% in 2001, on a par with the 24.5% level in 2000. About one-in-nine South Africans (or 5 million people) are living with HIV/AIDS.

In West and Central Africa, there is evidence of recent, rapid HIV spread. Senegal appears to still be reaping the rewards of its early and concerted AIDS response while, in Mali, HIV prevalence was measured at 1.7% in a community-based survey in 2001. National adult HIV prevalence rates passed the 5% mark long ago in countries such as Burkina Faso, Cameroon, Côte d’Ivoire, and Togo. Although the national prevalence rates for Nigeria, the most populous country in Africa, have been growing slowly from 1.9% in 1993 to 5.8% in 2001, some states in Nigeria are already experiencing HIV prevalence rates as high as 32%.

Data collected among hospital patients is even more frightening. Lewis et al. examined 1,226 consecutive patients admitted to medical and surgical wards in Blantyre, Malawi during two 2-week periods in October 1999 and January 2000 and noted that 70% of medical patients were HIV-positive and 45% had acquired immune deficiency syndrome (AIDS); 36% of surgical patients were HIV-positive and 8% had AIDS. Seroprevalence rose to a peak among 30–40 year olds; 91% of medical, 56% of surgical and 80% of all patients in this age group were HIV-positive.

Since the epidemic began, more than 60 million people have been infected with the virus and HIV/AIDS is now the leading cause of death in sub-Saharan Africa. In 2002, the epidemic claimed about 2.4 million lives in Africa, more than 70% of the 3.1 million deaths worldwide. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. Reductions in life expectancy compared to the ‘no AIDS’ scenario in selected countries are presented in Figure 3. The specific case for South Africa is also presented in Figure 4.

**Effect of HIV/AIDS on workforce development in Africa**

HIV/AIDS is expected to affect various institutions in several ways: increased sick leave and absenteeism, high medical expenses, low productivity, higher worker turnover, loss of skilled labour force, increased training costs, and increased expenditure on health and death benefits.

A retrospective investigation of mortality among Uganda’s highly trained manpower found that the mortality rate increased in this category after the emergence of AIDS. The increase was largely attributable to AIDS. The authors concluded that AIDS is causing considerable losses in training investments in Uganda.

In 1999/2000, Botswana’s diamond mining company, Debswana, carried out an institutional audit to gain a more detailed picture of the epidemic’s impact on the company and its operations. It discovered that retirements due to ill health and AIDS-related deaths had risen markedly. In 1996, 40% of retirements and 37.5% of deaths among workers were due to HIV/AIDS; by 1999, the proportion had risen to 75% and 59% respectively. Company hospitals were also recording more admissions of workers with HIV/AIDS-related conditions. A concerted response was called for. The audit examined skill levels, ease of training and replacement of relevant skills, as well as the related costs. It analysed risk-reduction strategies for critical posts, estimating liabilities.
were: Kaposi’s sarcoma in 72 patients, squamous cell carcinoma in two patients. Four other tumours not associated with HIV/AIDS were found. No hairy leukoplakia was found in this study. A similar pattern was recorded by Arendorf et al. in their study of the oral manifestations of HIV/AIDS in South Africans. The South African study also emphasised that different patterns of prevalence tend to emerge when inter-group comparisons are made of oral soft tissue diseases. A more recent study by Lewis et al. (2003) revealed the clinical signs strongly indicative of HIV to be oral hairy leukoplakia, shingles scar, Kaposi’s sarcoma, oral thrush and hair loss.

HIV-associated infections in sub-Saharan Africa differ markedly in their incidence from those in industrialised countries. Tuberculosis is the commonest cause of morbidity and mortality. Enteric pathogens such as microsporidiosis commonly cause disease as access to safe water is limited. Pneumocystis carinii pneumonia, which is the commonest opportunistic infection in industrialised countries, is uncommon in adults with HIV infection. This remains unexplained because P. carinii pneumonia is common in Black African HIV-infected children. Cytomegalovirus and Mycobacterium avium complex, which only occur in severely immune-suppressed individuals, are seldom found. One reason may be that survival after conversion to AIDS is relatively short in Africa.

Oral and general manifestations of HIV infection

In a study of 100 Zimbabwean HIV/AIDS patients, the general symptoms and signs were found to be: weight loss in 52, diarrhoea in 34, lymphadenopathy in 21 and herpes zoster in 12 patients. Ninety-two patients had oral lesions which consisted of: oral ulcerations in 26, candidiasis in 22, osteomyelitis in three, necrotising gingivitis in two and herpetic gingivostomatitis in one patient. Neoplasms recorded


Figure 3. Reduction in life expectancy compared to the ‘no AIDS’ scenario in selected countries: 2000–2005.

Figure 4. Estimated and projected deaths at ages 15–34, with and without AIDS in South Africa: 1980–2025.

and costs associated with benefits, developing systems of productivity monitoring, and considering potential treatment options and costs. The result was a landmark policy to cover 90% of the cost of antiretroviral treatment for workers and their spouses, and to require suppliers of goods and services to the company to have AIDS programmes in place. In addition, prevention measures were given top priority. The estimated percentage of workforce lost to AIDS in 2005 and 2020 in selected African countries is presented in Figure 5.
morbidity across sub-Saharan Africa are tuberculosis, bacterial infections, and malaria.

Factors contributing to spread of HIV/AIDS in Africa

A complex interaction of material, social, cultural and behavioural factors shape the nature, process and outcome of the epidemic in Africa.

In sub-Saharan Africa, some traditions and socioeconomic developments have contributed to the extensive spread of HIV-1 infection, including the subordinate position of women, impoverishment and decline of social services, rapid urbanisation and modernisation, and wars and conflicts. The sub-Saharan African region is plagued with incessant armed conflicts: Angola, Democratic Republic of the Congo, Lesotho, Rwanda, Sierra Leone, Liberia and others. In situations of conflict, the risk of sexual violence increases dramatically. There are large numbers of mobile, vulnerable and unaccompanied women who become easy prey for rapists. For example, a troubling rise in HIV prevalence has been detected in Angola. Although the country’s civil war has hindered data collection, a significant increase in prevalence has been documented among pregnant women attending antenatal clinics in the capital, Luanda. In 2001, 8.6% of the women were HIV positive, up from 1.2% in 1995.

Children who survive wars often end up as orphans with no skills to face the challenges in life. Prostitutes become the most likely way out, particularly for girls, and the vicious cycle of HIV/AIDS spread is thus perpetuated.

Populations in many parts of Africa are also becoming trapped in the vicious circle because the HIV-1 epidemic leads to high mortality rates in young and economically productive age groups, and thus leads to further impoverishment. Large differences in the spread of HIV/AIDS have been observed within sub-Saharan Africa. No single factor, biological or behavioural, determines the spread of HIV infection. The interplay of multiple factors obscures causal linkages and prevents categorical conclusions. Most HIV transmission in sub-Saharan Africa occurs through sexual intercourse, with unsafe blood transfusions and unsafe injections accounting for a fraction. A study in four African cities (Cotonou, Kisumu, Ndola and Yaoundé) revealed that the most common behavioural and biological factors in those cities with the highest HIV prevalence were: young age at women’s first sexual intercourse; young age at first marriage; age difference between spouses; the presence of HSV-2 infection and trichomoniass (a sexually transmitted infection); and lack of male circumcision.

The difference in HIV prevalence between the four cities could not be explained by differences in sexual behaviour. Any differences in sexual behaviour were outweighed by differences in other factors that influence HIV transmission, such as male circumcision and HSV-2 infection. These findings have important implications for the design of interventions. A few reports have challenged the conventional hypothesis that sexual transmission is responsible for more than 90% of adult HIV infections in Africa. These authors argue that HIV transmission through unsafe medical care may be a more important factor, than presently envisaged, in Africa’s HIV epidemic, and that a desire to maintain public trust in health care may have encouraged discounting of evidence. Although more research is warranted to clarify risks for HIV transmission through health care in Africa, epidemiological evidence indicates that sexual transmission continues to be the major mode of spread of HIV in Africa.

Prevention of HIV/AIDS

HIV in blood donors

The establishment of more effective measures for the prevention and control of HIV transmission through blood donors is recommended. Although donor-screening mechanisms presently being utilised are effective, there is still the need, in several African countries, to screen out high-risk donors. This is especially because of the existence of a ‘window period’ for HIV infection when conventional tests may not detect the presence of the virus. South Africa has been able to achieve some positive results in this regard due to its centralised blood-transfusion system.

Infection control

Knowledge of HIV/AIDS is still relatively poor among health
personnel and a significant proportion still use unacceptable cross-infection control procedures. As more HIV/AIDS infected individuals are presenting for treatment in the hospitals, there is a need to improve the use of universal infection control measures and to educate all categories of health care personnel in order to allay their fears and prevent discrimination that could militate against effective management of patients.

Earlier, Matee et al. had suggested that the high frequency of HIV infection calls for institution of infection control measures but recommended that such measures be tailored for the poor countries, with potentially high frequency of HIV infection and minimal resources, in order to make them relevant. Their recommendation was based on data collected at the Muhimbili Medical Centre in Tanzania in 1996 which indicated that the frequencies of HIV infection among patients attending the dental out-patient clinic, minor surgery, and those admitted in the dental ward were 9.4 per cent, 26.3 per cent, and 25.0 per cent, respectively.

It must be noted however that infection control precautions in dentistry are universal and cannot be easily dichotomised into measures for rich and poor settings. The need to pay more attention to laboratory safety regulation in sub-Saharan Africa has also been highlighted.

**Post-exposure prophylaxis**

Another source of concern is the low utilisation of post-exposure prophylaxis in the African setting. In a study by Naidoo, only one (5.6%) of the 18 respondents reporting a needle-stick injury in the previous six months sought after-care.

**HIV Infection and health care services**

In Chad, with prevalence rates estimated at 9%, the most cost-effective preventive options at under US$100 per infection prevented were peer group education of sex workers and screening of blood donors to identify infected blood before transfusion.

**Breastfeeding and HIV/AIDS**

Breastfeeding is a major health-promoting factor for infants and children in developing countries but the risk of mother-to-child transmission (MTCT) of HIV by this route is challenging traditional practices and health policies in low-resource countries.

**The role of traditional healers**

The challenges for HIV prevention indicate the need to examine in greater depth the culturally specific use of traditional healers and traditional theatre as channels of information that could serve to make HIV prevention initiatives more effective. There is however the need for greater cooperation between orthodox practitioners and the traditional healers.

**Antiretroviral treatment**

The benefit of most preventive regimens to the individual may be modest when compared with the effect of antiretroviral therapy. However, simple preventive therapies could reach a much wider population than is immediately feasible for expensive and complex antiretroviral regimens, and thus have the potential for substantial benefit at the population level. The availability of effective and affordable regimens to prevent HIV-related disease may also encourage people to seek HIV testing, combat denial, and help overcome the sense of powerlessness in Africa.

Although the introduction of highly active antiretroviral therapy (HAART) has decreased the incidence of AIDS-associated cancers in Western countries, only about 300,000 people in developing countries receive antiretroviral drugs. In sub-Saharan Africa, where 29.4 million people are infected, only 50,000 people had access to antiretroviral treatment at the end of 2002. The number of HIV/AIDS deaths compared to the people using antiretroviral by region is presented in Figure 6.

Recently, prophylactic cotrimoxazole treatment was shown to be effective in symptomatic HIV-infected adults in Africa. Tuberculosis preventive therapy is also effective, at least in the medium term. It is hoped that these two affordable interventions will become available to large numbers of patients identified in voluntary counselling and testing centres.

**HIV associated stigma**

This is still prevalent throughout Africa despite the spread of the epidemic and it is still a major problem. In Africa, the response to the AIDS epidemic has been marked by ignorance, fear, shame, and complacency, resulting in a spiraling epidemic. The stigma associated with HIV causes many women to hide their positive status and continue to spread the disease. One of the first South Africans to go public with her HIV status was stoned to death in 1998 by a group of men who said she had brought shame on their town. Voluntary Counselling and Testing (VCT) endeavours are being hampered by fear of confidentiality, hence, many only find out their diagnosis when they hit the AIDS stages. Success involves overcoming stigma, which undermines community action and blocks access to services. Work against stigma and discrimination has been effectively carried out in both the health sector and occupational settings.

**AIDS orphans**

The HIV/AIDS epidemic has given rise to major demographic changes
including an alarming number of orphans in sub-Saharan Africa. At the end of 2001, an estimated 14 million children worldwide had lost their mother or both parents to AIDS or related causes with Sub-Saharan Africa accounting for more than 80%. Without the care of parents or an appointed caregiver, children are likely to face extraordinary risks of malnutrition, poor health, inadequate schooling, migration, homelessness, and abuse."} Nyambedha et al. have described a rural community in western Kenya in which one out of three children below 18 years of age had lost at least one biological parent, and one out of nine had lost both. The main problems these children faced were lack of school fees, food and access to medical care. The high number of orphans overwhelmed the traditional mechanisms for orphan care, which were based on patriarchal kinship ties.

Bicego et al. reported on direct estimates of orphan prevalence in 17 countries during the period 1995–2000 and found a strong correlation between orphanhood prevalence and national adult HIV prevalence estimates lending support to the interpretation of the orphan crisis as, in large part, AIDS-related.

With increasing numbers of children who are orphaned, malnourished and having compromised immune systems (compounded by the HIV pandemic) the prevalence of conditions such as cancerous oris (noma) is likely to increase. Noma is a gangrenous infection that develops in the mouth and spreads rapidly to other parts of the face. The disease occurs mostly in conditions of poverty, poor hygiene and malnutrition. In sub-Saharan Africa the frequency in several countries is estimated to be 1–7 cases per 1,000 population, and as many as 12 cases per 1,000 in the most affected communities.

Although the disease can be managed medically and even totally prevented, an estimated 90% of children manifesting the disease die without receiving any care. The risk factors associated with an increased probability of noma developing include; malnutrition, poor oral hygiene, and a state of debilitation resulting from human immunodeficiency virus (HIV) infection, measles, and other childhood diseases prevalent in the tropics.

HIV/AIDS research

Although 70% of the estimated 42 million people living with HIV/AIDS are in Africa, only 6,569 (4.7%) of the 140,736 scientific publications on HIV/AIDS, from 1981 to 2000, are directly related to Africa. Also, only 2,119 (1.5%) of the 140,736 publications are dentally related (Table 3). This is an indication that Africa and also the dental community have contributed minimally to HIV/AIDS research. Factors that may have contributed to the paucity of research reports on HIV/AIDS from Africa include; high cost of research on HIV, inadequate funding, lack of standard laboratories and expertise, stigmatisation, and the relative secrecy associated with HIV/AIDS.

Political commitment by African governments

Effective responses to the epidemic require multiple partners, including governments, the business sector and civil society. The political commitment to turn the tide of AIDS now appears stronger than ever. Gatherings, such as the 2000 African Development Forum meeting and the Organisation of African Unity Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in April 2001, appear to be cementing that resolve. Nineteen countries have set up national HIV/AIDS councils or commissions at senior levels of government. Thirty-four countries across the region have completed national strategic AIDS plans, and another seven plans were near completion in March 2002. These plans serve as the basis for the more detailed strategies of various ministries, provinces, districts, civil society and the business sector.

Nigeria, Rwanda, South Africa and Uganda have come together...
Table 3  HIV/AIDS publications from Africa compared with the rest of the world (1981–2000)

<table>
<thead>
<tr>
<th>S/No</th>
<th>Continent</th>
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<th>%</th>
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* Data extracted from Pubmed, URL: http://www.ncbi.nlm.nih.gov/pubmed

Source: UNAIDS (2002)

Figure 7. Public expenditure on health as percentage of general government expenditure in African countries: 1998.

Conclusion

Many of the world’s most marginalised countries are in Africa and it is now apparent that these countries need long-term international solidarity, cooperation and financial support. More equitable investment and trade flows can help ensure that global economic progress also profits the world’s poor. So, too, could higher levels of Official Development Assistance in support of poverty-reduction strategies and improvement of social services. Since 1990, official development assistance provided to the 28 countries with the highest adult HIV prevalence rates (more than 4%) have fallen by a third. Where poverty, ignorance, poorly resourced or even non-existent medical facilities predominate, combating the spread of HIV infection becomes an onerous task.

HIV/AIDS poses the greatest single challenge to the marginalised poor of Africa, where it has found a malnourished, vulnerable, defenceless host. Collective response required from physicians and health professionals who must be at the forefront of restoring hope and a dignified quality of life. In sub-Saharan Africa, HIV/AIDS is not a security threat but a painful slow death that forces victims into exhausting their lifetime savings on expensive medicines and massive hospital bills. It leaves helpless orphans to struggle for survival in countries where government subsidy on education and healthcare has been long withdrawn so as to channel the meagre state resources into debt servicing. HIV/AIDS has given rise to numerous orphans on the African continent and there is an urgent need to look into the provision of basic needs of these orphans.

Although the factors contributing to the spread of HIV/AIDS in Africa have been identified, there is still disagreement with regard to the relative contribution of each of these factors to the rapid spread of the epidemic. This is very crucial to the success of health education and other preventive measures. Further research is therefore suggested in this direction.

References


