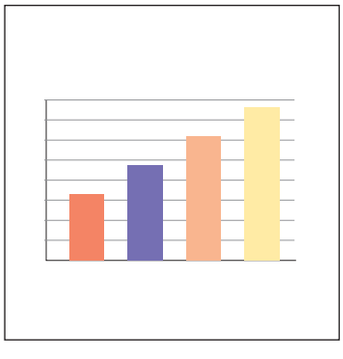
UNAIDS/ECA

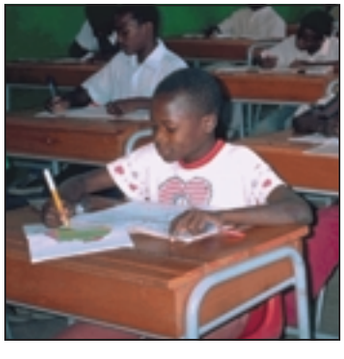
Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

AIDS in Africa

Country by country

Economic Commission for Africa (ECA)





- HIV/AIDS epidemiology
- economic impact
- national response to the epidemic
- selected socioeconomic indicators

Africa Development Forum 2000

AIDS: the Greatest Leadership Challenge

AIDS in Africa

Country by country

UNAIDS/00.30E (English original, September 2000)

© Joint United Nations Programme on HIV/AIDS (UNAIDS) 2000.

All rights reserved. This document, which is not a formal publication of UNAIDS, may be freely reviewed, quoted, reproduced or translated, in part or in full, provided the source is acknowledged.

The document may not be sold or used in conjunction with commercial purposes without prior written approval from UNAIDS (contact: UNAIDS Information Centre).

The views expressed in documents by named authors are solely the responsibility of those authors.

The designations employed and the presentation of the material in this work do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers and boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned.

Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland

Tel: (+41 22) 791 46 51 ; Fax: (+41 22) 791 41 87

E-mail: unaids@unaids.org Internet: http://www.unaids.org

AIDS in Africa
Country by country

African Development Forum 2000

Geneva, Switzerland
December 2000

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

Economic
Commission
for Africa (ECA)

Table of contents

Introduction 5

Country profiles

- Algeria 11
- Angola 15
- Benin 19
- Botswana 23
- Burkina Faso 29
- Burundi 33
- Cameroon 37
- Cape Verde 41
- Central African Republic 45
- Chad 49
- Comoros 53
- Congo 57
- Côte d'Ivoire 61
- Democratic Republic of the Congo 65
- Djibouti 69
- Egypt 73
- Equatorial Guinea 77
- Eritrea 81
- Ethiopia 85
- Gabon 89
- Gambia 93
- Ghana 97
- Guinea 101
- Guinea Bissau 105
- Kenya 109
- Lesotho 115

Country profiles continued

- Liberia 119
- Libya Arab Jamahiriya 123
- Madagascar 127
- Malawi 131
- Mali 137
- Mauritania 141
- Mauritius 145
- Morocco 149
- Mozambique 153
- Namibia 157
- Niger 163
- Nigeria 167
- Rwanda 171
- Sao Tome & Principe 175
- Senegal 179
- Seychelles 183
- Sierra Leone 187
- Somalia 191
- South Africa 195
- Sudan 201
- Swaziland 205
- Togo 209
- Tunisia 213
- Uganda 217
- United Republic of Tanzania 221
- Zambia 229
- Zimbabwe 235

INTRODUCTION TO THE ADF COUNTRY PROFILES

As a resource for the delegates at this African Development Forum 2000 devoted to the topic of HIV/AIDS, UNAIDS is pleased to provide the following country profiles. Together, the profiles help to paint a picture of the current state of the HIV epidemic in Africa, its impact on the social and economic fabric, and the response thus far of the African nations to the unprecedented crisis caused by HIV/AIDS. For the selected indicators used, they are as complete a compilation as possible, given the available data from the African countries and from UNAIDS and WHO sources. Additional information on AIDS in Africa is available from the UNAIDS Web site (www.unaids.org) and other sources, including the bibliographical references contained in this document.

The country profiles are divided into four sections:

- The epidemiological situation of HIV/AIDS;
- The economic impact of HIV/AIDS;
- The management and implementation of the national response to HIV/AIDS;
- A short list of basic socioeconomic indicators, followed by a list of references.

The Epidemiological Indicators

The epidemiological data presented here come from the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Initiated in November 1996, the Working Group aims to strengthen national, regional and global networks for improved monitoring and surveillance. Collaborating closely with national AIDS programmes and a range of national and international institutions, it strives to compile the best available information and improve data quality for informed decision-making and action planning.

Through its consultations, the Working Group has developed a framework to standardize the collection of key data on the status and trends of the HIV epidemic and patterns of risk and vulnerability in the population. The epidemiological section of the country profiles contains the most recent data on behaviours, such as casual sex and condom use, that affect the transmission of HIV.

The data were sent to national AIDS programmes in Africa for verification, but not all countries responded to this request. In some countries, data are not currently being collected for the standard indicators. In others, information was available from studies that followed different protocols and definitions. Where possible, this information has been included in the profiles.

To be of greatest use to decision-makers in fighting the epidemic, additional data (for example, on care and support for HIV-infected persons) need to be developed and collected. Information on HIV prevalence (the number of infected individuals) and prevalence rate (the number of individuals affected per 100 or per 1000) also needs to be increasingly collected for different age groups (e.g. 0-14 years of age, 15-24, etc.). This will lead to a better understanding of the spread of the virus and will facilitate interventions for those groups at greatest risk.

The UNAIDS/WHO Working Group is ready to assist countries that wish to improve their HIV epidemiological systems by providing technical support to them and by encouraging donor agencies to offer technical and financial backing. The Group also welcomes suggestions for additional indicators or information, regardless of protocols or definitions used, that have proven useful in national AIDS programme management.

Notes on the Epidemiological Indicators Used in these Profiles

The *number of people living with HIV/AIDS at end 1999* represents *estimates* rather than an exact count of infections, and the same applies to deaths. Thus, there may be minor discrepancies between the total estimate and the sum of the separate estimates for adults and children. Figures include all individuals with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1999. The approach to estimating HIV prevalence and AIDS deaths varies according to whether the epidemic has reached the general population or is still largely concentrated in groups with high-risk behaviour.

In most countries in sub-Saharan Africa, the HIV epidemic is largely driven by heterosexual transmission and has spread to the general population. In these countries, HIV surveillance is largely based on tests performed among pregnant women attending antenatal clinics selected as 'sentinel' sites. Anonymous specimens of blood left over from tests performed as part of routine care for pregnant women are tested for antibodies to HIV. Many countries in sub-Saharan Africa have measured HIV prevalence in these antenatal clinics more or less regularly since the end of the 1980s.

For many countries in North Africa, not enough data were available to produce an estimate of HIV prevalence for end 1999. For each of these countries, the 1994 prevalence rate published by the WHO Global Programme on AIDS (AIDS—Global Data. *Weekly Epidemiological Record* 1995; **70**(50):353-357) was applied to the country's 1999 adult population to derive the numbers presented here.

In regions where life-prolonging therapy is not widely available, simple back-calculation procedures are used to generate estimates of new HIV infections and of HIV-related deaths. These procedures are based on the well-known natural course of HIV infection, which determines the relationship between HIV incidence, prevalence and mortality. Similarly, estimates for HIV infections among children can be calculated. These estimates are based on age-specific fertility rates in countries and on region-specific rates of mother-to-child transmission, which are documented in numerous studies. The methodology used to produce the country-specific estimates in the profiles has been described in full elsewhere (Schwartländer et al, *AIDS,* 1999, **13**(17):2445-2458).

One of the key indicators on the *demographic impact of HIV/AIDS* used here is the estimated number of children in the country, as of end 1999, having lost their mother or both parents to AIDS before age 14, since the AIDS epidemic began. Some of the orphaned children included in this cumulative total are no longer alive, while others are no longer under 14. Another key indicator of *demographic impact* is the estimated number of adults and children who died of AIDS during 1999.

Behavioural indicators have been developed and field-tested in the monitoring of many national AIDS programmes. A detailed description of the indicators has been published as *A Methods Package: 1, Prevention of HIV Infection*, WHO/GPA/TCO/SEF/94.1 Geneva, 1994. Newer guidelines on indicators and surveys of risk behaviours are currently under preparation.

Under *measured HIV prevalence,* the most recent data from pregnant women attending antenatal care clinics in major urban areas are summarized. The median, minimum and maximum prevalence rates are provided. The measured HIV prevalence in pregnant women in both urban and rural antenatal clinics is presented in the map, for the period 1997-1999, in

circles, and for the period 1994-1996, in squares. The size of the circles and squares reflects the magnitude of the measured HIV prevalence.

The Economic Indicators

Since the AIDS epidemic has the greatest impact on those in their most productive years, the spread of the disease is having devastating consequences at the household, community and sectoral level, with significant negative consequences for the national economy as a whole.

To date, there has been little systematic analysis of the economic impact of AIDS, even though much anecdotal evidence has been collected. In these country profiles, UNAIDS has compiled existing evidence on the economic impact of AIDS from a range of international and national data sources, including reports, scientific papers, books, censuses and surveys.

The selected indicators have been chosen to give a broad picture of the economic impact of the epidemic, examining how both the demand and supply for various sector services and products (education, health care, agricultural goods) have been affected by the HIV epidemic in Africa. They should be seen as a first step towards the collection and use of a standard set of economic impact indicators on the epidemic.

Impact on the macroeconomy is measured here by the percentage change in GDP growth over time, as a result of HIV/AIDS. In other words, how much lower the national income is growing because of AIDS, as compared to a situation in which there is no HIV/AIDS. Recent studies suggest that AIDS slows economic development through its impact on key determinants of long-term growth: macroeconomic policy, societal institutions, human capital and investment and social capital.

Impact on households is calculated as the reduction in household savings or wealth, or AIDS-related expenditures as a percentage of household income. There are also some limited data on how HIV/AIDS is affecting the distribution of income within a few African countries.

***The impact of AIDS on agricultural* production** is expressed as a percentage change in production. This impact is felt through falls in labour productivity and a reduction in income which, in turn, can cut crop yields and agricultural output. These changes tend to be measured differently in smallholder farming and on larger commercial farms, where the supply of labour is more elastic. Since the majority of people in Africa depend on the smallholder agriculture sector for their livelihood, the observed negative impact of HIV/AIDS on household food security shows how the epidemic is undermining the economic basis of many African countries.

Impact on the business sector is measured in the profiles as a percentage reduction in enterprise profits, or as an increase in costs to the firm. A number of studies have examined the costs of AIDS in terms of higher absenteeism, increased payments for medical care and funerals, plus the costs of worker replacement and training.

The impact of AIDS on the education sector is portrayed in terms of a reduction in school enrolments as a result of infant and child deaths and decreased fertility, or in terms of the numbers of teachers ill and dying because of AIDS. In this report, the latter is expressed as the number of primary school pupils who lost a teacher to AIDS in 1999, or as mortality rates among education professionals.

A number of studies on AIDS in education have been conducted in recent years, including work by UNESCO, UNICEF, USAID, and UNAIDS. These mostly focus on teacher deaths, rather than on how AIDS is affecting the quality or process of education. On the supply side, there is some information from household surveys on enrolment, absenteeism, and school dropout rates among AIDS orphans.

The impact of AIDS on the health sector is analysed in the country profiles mainly in terms of the share of hospital beds occupied by HIV-positive patients, or the percentage of public health spending going to AIDS prevention and care services. Surprisingly, perhaps, there are virtually no country-based data on the numbers of health professionals infected with HIV or dying from AIDS.

A major challenge is to accurately measure the number of HIV-positive patients in the health system. Due to low levels of HIV testing and counselling in Africa, most people do not know their HIV status. However, some studies have managed to use anonymous testing, while, in others, patient records have been reviewed for AIDS-related symptoms. HIV-related health care costs can also be modelled using variables such as level of access to care, HIV prevalence rates, and distribution of health infrastructure. Studies in this report are based on these methods.

Indicators on Management and Implementation of the National Response to HIV/AIDS

The indicators in this section of the country profiles measure the existence and effectiveness of African countries' national strategic AIDS plans and on-the-ground programs.

Strategic planning is a dynamic and participatory process that involves all sectors and levels of government as well as NGOs, private sector, religious organizations and international development partners (UN and bilateral donors) in order to produce a multisectoral and decentralized response to the epidemic. Since the concept of national strategic planning for HIV/AIDS was started in 1997, more than 20 countries in sub-Saharan Africa have developed National Strategic Plans or Frameworks. Several countries are now at the stage of preparing sectoral plans for government ministries, as well as provincial and district-level implementation plans. At this stage, the information available does not enable us to present an accurate image of the epidemic at the community level.

The information presented in this part of the profiles comes from a wide variety of sources, including UN country 'theme groups' on HIV/AIDS, national government spokespeople, UNAIDS country representatives, and others.

The AIDS Country Profiles—a Work in Progress

As you will note in the following pages, the available data on the state of the HIV/AIDS epidemic in Africa and its economic impact paint an alarming picture. The data on the response show that much is being done (a hopeful sign) but also that much more effort is required to stem the tide of the epidemic and help those infected and affected.

The profiles also highlight the many serious gaps in the African AIDS data. In this sense, this document should help reinforce the call for the development of key indicators and, above all, the collection and application of more data on the epidemiological and demographic aspects of

the epidemic, its negative social and economic consequences, and the policy and programme responses of countries, districts, communities, and individuals.

In this sense, the UNAIDS Secretariat, its seven cosponsoring agencies, and many of UNAIDS' other partners are strongly committed to improving the AIDS country information available for Africa and for other developing countries. UNAIDS plans to work on several fronts in the coming years to create a more effective AIDS data system, including the development of a national AIDS response data base and support to international reference groups for HIV epidemiological, demographic, and economic indicators and analyses.

At the same time, national governments in Africa, regional political organizations and academic institutions, African NGOs, and others in the continent will need to play an active role in defining, collecting, and analysing these AIDS-related data, and using them to draw appropriate policy and programme conclusions.

As these efforts bear fruit, the AIDS country profiles presented in this document can be substantially enriched so that they can help to raise awareness and a sense of urgency about the epidemic and help policy-makers, community leaders, and motivated individuals to mount an effective response to the threat of HIV/AIDS.

Note: The maps featured in the report were produced by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, in collaboration with the UNICEF/WHO HealthMap Programme. They show the location and HIV prevalence of HIV sentinel sites in relation to population density, major urban areas and communication routes.

Algeria

HIV/AIDS epidemiological summary

There is no information available on HIV prevalence among antenatal clinic women.

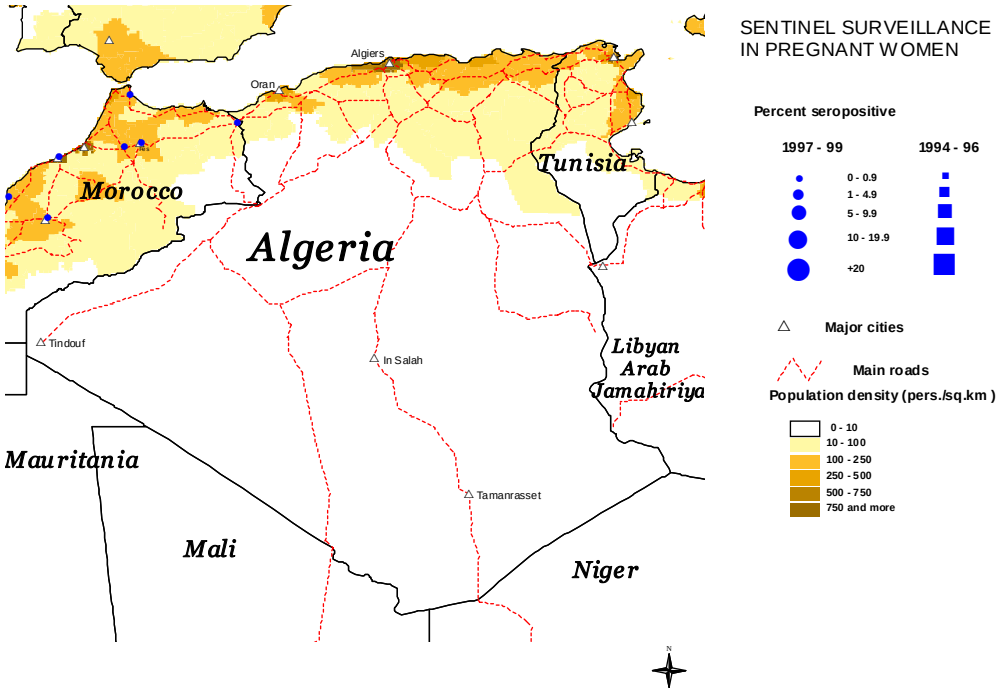
Some limited testing of sex workers was conducted in 1988 in Algeria. One per cent of sex workers tested in Constantine and Oran were HIV-positive. Outside of these urban areas, no evidence of HIV infection was found among sex workers tested in Tlemcen or Blida, 1988.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	11 000	0.07	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Algeria were found in the literature review. However, if the epidemic develops at the same pace here as it has in many African nations, the impact will be felt in most sectors. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Although the National AIDS Control Programme (NACP) (Programme national de lutte contre le SIDA - PNLS) has existed since 1988, it was only formally adopted by the government in November 1999.

Source: Ministry of Health and Population

Date: November 1999

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports	X	
Others (prisons, immigration)	X	

Comments/Key elements: Eighteen ministries are involved in the NAP in Algeria, with that of Public Health as the lead ministry in this area.

Source: Theme Group, UNAIDS

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	x

Comments/Key elements: HIV/AIDS infection is regulated in Algeria by dispositions of the laws and regulations on health. In no case does the Penal Code apply, even if the infected person is a prostitute or drug-user.

Source: Ministries of Public Health and Justice

Date: 1999

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: An inter-ministerial National Committee for the fight against STD/HIV/AIDS exists. Its president is appointed by the Minister of Public Health and Population.

Source: Ministry of Public Heatlh

Date: 1999

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: There does exist, however, a Mid-Term Plan (MTP II). Following recommendations of an on-site evaluation mission, a process of strategic planning will be set up conjointly with the Theme Group and the national partners.

Source: Theme Group, UNAIDS

Date: July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: Clear and objective priorities exist in the MTP-II, but strategies have not been adopted.

Source: Ministry of Public Health, MTP II

Date: 1995-1999

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: Following the last meeting of the enlarged TG, the heads of agencies and donors undertook to support the process of strategic planning.

Source: Theme Group, UNAIDS

Date: July 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	30 774	UNPOP
Population aged 15-49 (thousands)	1999	16 115	UNPOP
Annual population growth (%)	1990–1998	2.3	UNPOP
% of population urbanized	1998	56	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.3	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1997	1500	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-0.5	World Bank
Human Development Index rank (HDI)	1999	109	UNDP
% population economically active	-	26.6	ILO
Unemployment rate	1996	26.4	ILO
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	62	UNESCO
Adult male literacy rate	1995	74	UNICEF
Adult female literacy rate	1995	49	UNICEF
Male secondary school enrolment ratio	1996	64.8	UNESCO
Female secondary school enrolment ratio	1996	61.6	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	29	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	5	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	160	WHO
Life expectancy at birth	1998	69	UNDP
Total fertility rate	1998	3.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	41	UNICEF/UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	-	-	-

References

Angola

HIV/AIDS epidemiological summary

Limited HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s from Angola. In Luanda, the major urban area, HIV prevalence among antenatal women tested increased from 0.3% in 1986 to 1% in 1995. Outside of the major urban areas, 7% of antenatal women tested in Cabinda Province in 1992 tested positive for HIV-1 and/or HIV-2 (HIV prevalence by type is not available). Between 1993 and 1996, HIV-1 prevalence increased from 7% to 9% of antenatal clinic attendees tested. In 1995, 0.5% of antenatal women tested in Namibe Province were HIV-1-positive.

There is no information available on HIV prevalence among sex workers.

In 1987-88, 13% of male STI clinic patients tested in Dundo were HIV-positive. In 1992, 3% of female STI clinic patients tested in Luanda were HIV-positive.

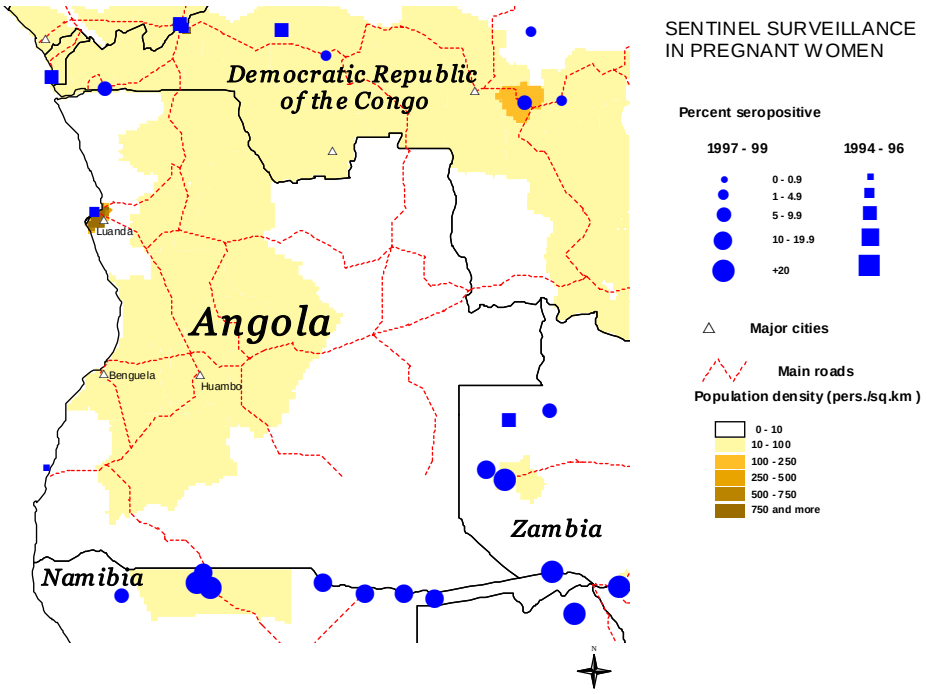
In 1995, 1% of military personnel tested in Luanda were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO June 2000	160 000	150 000	2.78	82 000	7900

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	98 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	15 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1997	14–19	38.1	36.3
Reported non-regular sexual partnership over a 12-month period (%)	1997	15–49	28.4	

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1995	1.2	1.2	1.2



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Angola were found in the literature review. Only an international study exploring the impact of the epidemic on education provided any information on the potential impact in the country. With the instability of such a war-torn nation, it is likely that the country is vulnerable to fast rising rates of prevalence. The impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, more detailed studies are required to understand the full impact to this sector. The education study shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are required to help us understand the current level of demand on the health sector due to AIDS and how supply might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of nearly 1 million primary school students, 3300 children would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: The document was formulated and published by the National Assembly in the 1980s.

Source: National AIDS Programme

Date: 22 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military	X	
Workplace		X
Sports		X
Others		

Comments/Key elements:

Source: National AIDS Programme

Date: 22 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: A parliamentary commission, led by the Parliamentary Women's Group, was created last April, with the mandate to formulate a preliminary project for legislation on HIV/AIDS. This commission integrates the NAP, UNAIDS (represented by the UNAIDS/CPA and the UNFPA Representative), national lawyers, Ministry of Justice, Ministry of Labour, USAID, PLWA and ANASO (AIDS NGO Network). For this, four public meetings were held in Luanda, Huila, Bengo and Namibe Provinces to collect information from different sectors of society about what should be prioritized in law relating to HIV/AIDS. On 22 June 2000, a specific session of the National Assembly, led by the President of the Parliament, was devoted to discussing the current HIV situation in Angola. Besides legislators, the meeting included the presence of ministers, representatives of the UN system, the Bishop of Luanda, academics and members of the Diplomatic corps. The results of the meeting had an impact in the four provinces noted above. Brazil's experience in the formulation of legislation on HIV/AIDS, raised by a Brazilian lawyer, was also considered. UNAIDS/CPA presented the current HIV situation in Africa and the role of international partnership. The Minister of Health presented the current STI/HIV/AIDS situation in Angola and the major objectives and strategies of the National Strategic Plan. Later, a similar session was carried out with representatives of civil society, at which important suggestions were made by the participants for the legislation process in Angola. The first draft is expected to be ready soon.

Source: UNAIDS/CPA

Date: 22 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: There is already a committee at the National Assembly, noted above, as well as a coordination body involving vice-ministers from different sectors, including the Representative of the President and the Representative of the First Lady, working together within the framework of the recently approved National Strategic Plan.

In the last three years, there has been a considerable upsurge in the involvement of the top leadership of the country in support of the national campaign against HIV/AIDS. They include the President of Angola, the National Assembly, the Ministries, the Cabinet of the First Lady, and the top army leadership. (A civil-military alliance was recently signed on STD/HIV/AIDS.)

Source: UNAIDS/CPA

Date: 22 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The National Strategic Plan was formulated in June 1999 and approved by the Parliament last December. A Resolution was made to the Government to technically and financially support the plan. Several specific projects are in course, such as legislation, a mass media campaign, and support for people infected or affected by HIV/AIDS.

Source: UNAIDS/CPA

Date: 22 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: The priorities were defined after a situation analysis and different workshops with Ministries (17), the National Assembly, UN agencies, donors, NGOs, representatives of PLWA, the university, and churches, among others.

Source: UNAIDS/CPA

Date: 22 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
x	

Comments/Key elements: Funds were allocated by USAID (US$ 3 million) for social marketing of condoms, IEC, and approximately US$ 350 000 came from the government. A new specific budget for HIV/AIDS is expected to be released by the President of the country, according to the information released by the Vice-Minister of Foreign Affairs during the bilateral commission USA/Angola in May 2000 to support the implementation of the National Strategic Plan.

Source: National AIDS Programme

Date: 22 June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	12 479	UNPOP
Population aged 15-49 (thousands)	1999	5367	UNPOP
Annual population growth (%)	1990–1998	3.2	UNPOP
% of population urbanized	1998	31	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.8	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	260	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-2.5	World Bank
Human Development Index rank (HDI)	2000	160	UNDP
% of population economically active	1997	45	UNDP
Unemployment rate	1997	32.1	INE
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1997	43	INE
Adult male literacy rate	1997	56	INE
Adult female literacy rate	1995	28	INE
Male secondary school enrolment ratio	1996	14.2	UNESCO
Female secondary school enrolment ratio	1996	9.4	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	48	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	18	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	1854	MOH
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	6.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	123	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1996,1990—1999	8	UNICEF/UNPOP
% of births attended by trained health personnel	1996	23	MICS/INE
% of one-year-old children fully immunized-DPT	1995–1998	36	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

Benin

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s in the major urban areas of Cotonou, Atlantique and Porto Novo. HIV prevalence among antenatal women tested in these areas increased from no evidence of infection in 1986-87 to 4% in 1998. In 1998, HIV prevalence ranged from 3% to 6%. Outside major urban areas, sentinel surveillance information is available from various sites, since 1990. Median HIV prevalence among antenatal women tested at these sites increased from less than 1% in 1990 to 2% in 1998. The range of HIV prevalence in 1998 from 26 sites was from no evidence of infection to 14% of antenatal women tested.

HIV prevalence among sex workers tested in Cotonou and other towns increased from 5% in 1987 to 54% in 1996. In 1990, 23% of sex workers tested in Zou Province were HIV-1- and/or HIV-2-positive. In 1995-96, 47% of sex workers tested in Atacora, Borgou, Mono and Zou Provinces tested positive for HIV-1.

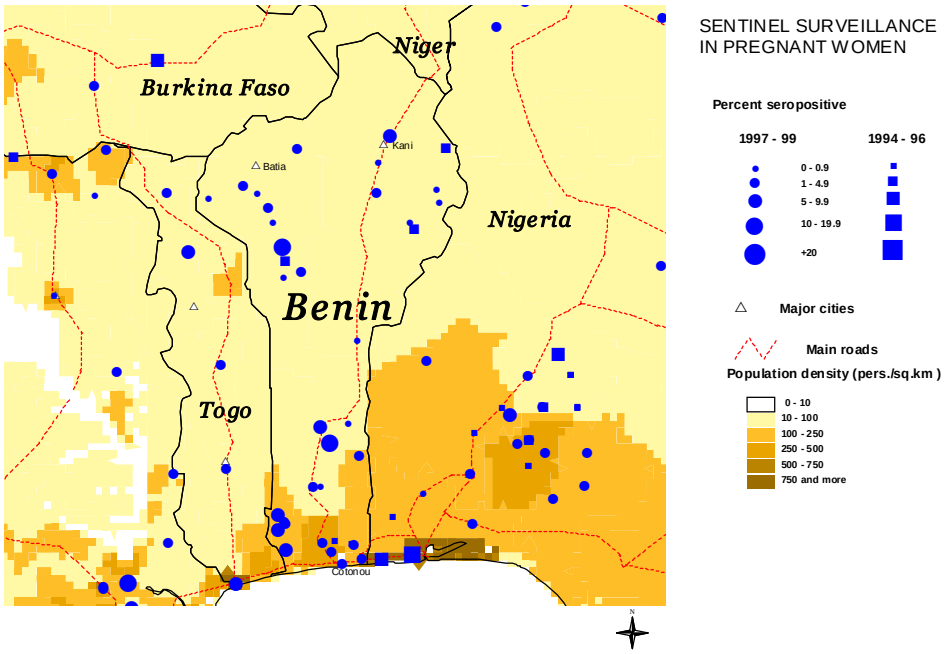
In 1989-90, 14% of male STI patients tested in Cotonou were HIV-positive. In 1998, 3% of STI patients tested in Cotonou were HIV-positive. Between 1995 and 1997, HIV prevalence among STI patients tested in Borgou and Mono Provinces increased from 4% to 9%. In 1998, HIV prevalence ranged from 4% to 32% of STI clinic patients tested at three sites.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	70 000	67,000	2.45	37 000	3000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	22 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	2613	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1997	15–49	31.7	11.8

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	3.71	2.94	5.94



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of HIV/AIDS in Benin are limited. Most available studies focus on the impact of the epidemic on health, not on the economic impact on the household in rural areas and on agriculture. One survey on businesses shows the important impact HIV/AIDS is having on inflating costs in this sector. In the education sector, the current primary school enrolment is 65.6% and a steady loss of teachers to AIDS mortality is likely to impede future gains to be made in enrolment figures and lead to a discontinuity in teaching. The health sector studies demonstrate that there is a large gap in funding to meet the full needs of a scaled-up care and prevention programme, equivalent to US$ 2–3 per capita and 0.9% of GDP.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

In a 1998 survey of employees in 14 firms, a loss in savings, a reduction in hours at work or bankruptcy as a result of AIDS were identified in 84% of the 68 families affected by an AIDS death (1).

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Supply: In a 1998 survey of 14 firms, AIDS was found to increase costs in six of these firms, and lead to a decrease in profits for the remaining eight (1).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 750 000 primary school students, 1800 would have lost a teacher to AIDS in 1999 (2).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: In 1995, a model showed total costs of AIDS to the health sector to increase from 97 million FCFA in 1995 to between 448.3 million FCFA (low case) and 815 million FCFA (high case) by 2025 (3).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes nationwide is calculated to be between US$ 12 million and US$ 18 million (4).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: MTP II, 1996 – 2001

Source: UNAIDS

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: No specific sectoral policy, but many partners have developed sectoral projects.

Source: UNAIDS

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	x

Comments/Key elements:

Source: UNAIDS

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: High-level location of structure in support of national response being explored.

Source: UNAIDS

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: Under development

Source: UNAIDS

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	NA

Comments/Key elements:

Source:

Date:

Existence of budget for implementation of the national strategic plan

Yes	No
	NA

Comments/Key elements:

Source:

Date:

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	5937	UNPOP
Population aged 15-49 (thousands)	1999	2681	UNPOP
Annual population growth (%)	1190–1998	2.7	UNPOP
% of population urbanized	1998	39	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.3	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	380	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.7	World Bank
Human Development Index rank (HDI)	2000	157	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	37	UNESCO
Adult male literacy rate	1995	49	UNESCO
Adult female literacy rate	1995	26	UNESCO
Male secondary school enrolment ratio	1996	23.4	UNESCO
Female secondary school enrolment ratio	1996	10.3	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	41	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	990	WHO
Life expectancy at birth	1998	53	UNPOP
Total fertility rate	1998	5.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	86	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	37	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	60	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	81	UNICEF

References

(1) Ministère de la Santé Publique. *Impact Socio-Economique du VIH/SIDA sur les Secteurs Porteurs de l'Economie au Bénin*. Cotonou, Programme des Nations Unies pour le Développement, 1998.

(2) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(3) Le Programme National de Lutte contre le SIDA. *Le SIDA au Bénin*. L'Unité de Planification de la Population, le Ministère de la Santé, de la Protection Sociale et de la Condition Féminine, et le Ministère du Plan, de la Restructuration Economique et de la Promotion de l'Emploi, 1998.

(4) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Botswana

HIV/AIDS epidemiological summary

HIV sentinel surveillance of antenatal clinic attendees began in Gaborone in 1990. Since 1992, National Sentinel Surveillance Surveys have been conducted in Botswana. The major urban areas include Gaborone, Francistown, and Selebi-Phikwe. Median HIV prevalence among antenatal clinic attendees tested in the major urban areas increased from 6% in 1990 to 43% in 1998 with a range of 39% to 50% in 1998. Age detail is available from Gaborone and Francistown for 1992, 1993, 1995, 1997 and 1998. HIV prevalence among tested antenatal clinic attendees under 20 years of age increased from 18% in 1992 to 33% in 1998. Among women 20–29 years of age, 45% to 48% tested were HIV-positive. Outside of the major urban areas, median HIV prevalence increased from no evidence of infection in 1985–87 to 30% in 1995 and has remained at that level through 1998. In 1998, HIV prevalence ranged from 22% to 38%. Age detail is again available for 1992, 1993 and 1995, with complete age breakdown available for the total country for 1997 and 1998. HIV prevalence among tested antenatal clinic attendees under 20 years of age increased from 7% in 1992 to 36% in 1995. In 1998, 29% of antenatal clinic attendees under 20 years of age tested HIV-positive. However, 44–45% of 20–29-year-olds were HIV-positive.

There is no information available on HIV prevalence among sex workers in Botswana.

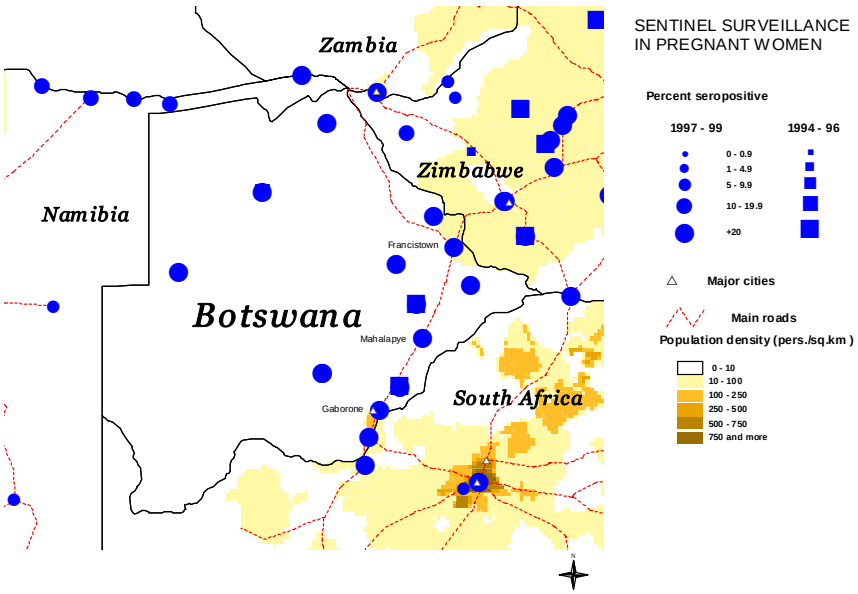
Information on HIV prevalence among male STI clinic patients has been available from Gaborone since 1992, Francistown since 1993 and Selebi-Phiwke in 1998. HIV prevalence increased from 22% in 1992 to 60% in 1998 among STI patients tested. Outside the major urban areas, HIV prevalence among male STI patients tested increased from no evidence of HIV infection in 1985–87 to a median of 53% in 1998. In 1998, HIV prevalence among male STI clinic patients tested ranged from 36% to 64%.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15–49)	Adult rate (%)	Women (15–49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	290 000	280 000	35.8	150 000	10 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	66 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	24 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1996	18–25	-	85.0
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	43	39.1	49.3



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Botswana are relatively extensive when compared with many countries in sub-Saharan Africa. Preliminary results of a recently developed model on the macroeconomic impact of AIDS reveal that the impact is substantial. At the household level, HIV is resulting in real decline in income—all the more so in the poorest households. No data were found for the impact in the agricultural sector. Firms are having to meet the cost of AIDS-related medical and funeral expenses which, in turn, increases their wage bill. In the public sectors, the education study shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. The health sector is having to cope with hospitals where over 50% of beds are occupied by patients with AIDS-related illness and yet there are still extensive investments required to scale-up AIDS programmes, equivalent to US$ 7 – US$ 10 per capita and 0.3% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 1.1% by 2010 (1).

Economic impact of HIV/AIDS on households

A model shows a decline in per capita household income of 8%, on average, and of 13% in the poorest households over 10 years from 1998 (2).

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Supply: Projections showed that, between 1996 and 2004, the impact of HIV on five surveyed firms could increase seven times to equal 4.9% of their total wage bill (3). The annual cost of AIDS per employee was US$ 237 and US$ 268 in the Botswana Diamond Valuing Company and the Botswana Meat Commission, respectively, in 1997 (4).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 350 000 primary school students, 14 000 would have lost a teacher to AIDS in 1999.

Demand: No indicators available

Economic impact on the health sector

Supply: The percentage of hospital beds occupied due to HIV-related causes was estimated to be 60% in 2000 (5).

Demand: No indicators available

Resource gap: The scaling-up of HIV/AIDS programmes nationwide is estimated to cost between US$ 11 million and US$ 16 million per year (6) cited in (1).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: A national AIDS policy was produced in 1993.

Source: UNAIDS Botswana

Date: May 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health	X	
Military	X	
Workplace	X	
Sports		
Others (youth, orphans and vulnerable children)	X	

Comments/Key elements: Not available

Source: UNAIDS Botswana

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Botswana

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A National AIDS Council has been established, chaired by the President of Botswana and including representatives from government, NGOs, religious organizations, private sector, PLWA. Permanent Secretaries are members of NAC.

A National AIDS Co-ordinating Agency (NACA) (not yet constituted) will serve as secretariat to the council. The Director of NACA is at the level of Permanent Secretary. NACA will be housed in the Ministry of Health. Selection of the NACA team has been moving with great deliberation.

In each Ministry (including Ministry of Health) a sectoral committee for HIV/AIDS has been established.

District Multi-Sectoral AIDS Committees (DMSACs) are in place in 10 of the country's 24 districts. These pre-date the recent changes in the national coordination structure. It is planned that, by the end of 2000, another six DMSACs will have been formed.

Source: UNAIDS Botswana

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The current National Strategic Plan, Botswana HIV and AIDS Second Medium Term Plan MTP II, is covering the period 1997–2002. In addition, a national operational plan for HIV/AIDS activities in Botswana has been developed, covering the period 1999–2000.

Source: UNAIDS Botswana

Date: May 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: The operational plan focuses on five major components: Leadership, Management and Co-ordination; Information, Education, Communication and Counselling; Care of people living with HIV/AIDS, Control of STIs; Care of orphans; and Epidemiology and Research.

Source: UNAIDS Botswana/The Operational Plan for HIV/AIDS Activities in Botswana (1999–2000)

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: The operational plan for the period 2000–2001 has been costed.

Source: UNAIDS Botswana

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	1594	UNPOP
Population aged 15–49 (thousands)	1999	786	UNPOP
Annual population growth (%)	1990–1998	2.6	UNPOP
% of population urbanized	1998	64	UNPOP
Average annual growth rate of urban population (%)	1990–1998	7.9	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	3310	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.0	World Bank
Human development index rank (HDI)	2000	122	UNDP
% population economically active	-	-	-
Unemployment rate	1995	21.5	ILO
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	90	UNESCO
Adult male literacy rate	1995	81	UNESCO
Adult female literacy rate	1995	60	UNESCO
Male secondary school enrolment ratio	1997	64.3	UNESCO
Female secondary school enrolment ratio	1997	71.0	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	33	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	250	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	4.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	60	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	48	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	78	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	82	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Greener, R. *Impacts of HIV/AIDS on Poverty and Income Inequality*. Botswana, Botswana Institute for Development Policy Analysis. 4 October 2000.

(3) Greener, R. *Impact of HIV/AIDS and Options for Intervention*: Results of a Five Company Pilot Study. Paper written for the Botswana National Task Force on AIDS at the Workplace. BIDPA. Working paper #10, 1997.

(4) Roberts, M. and Rau, B. *Private Sector AIDS Policy African Workplace Profiles*: Case Studies on Business Managing HIV/AIDS. The AIDSCAP Electronic Library, 1997.

(5) Makhema, M. J. *Health Care Costs for Patients with HIV/AIDS*. Princess Marina Hospital, Gaborone, Botswana, 2000. Ref Type: Electronic Citation.

(6) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Burkina Faso

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s from Burkina Faso. In Burkina Faso, Ouagadougou and Bobo-Dioulasso are considered major urban areas. From 1985-87 to 1996, HIV prevalence among antenatal women increased from nearly 2% to 10%. In 1997-8, 7% of antenatal clinic attendees were HIV-positive. Outside of major urban areas, median HIV prevalence among antenatal clinic attendees has ranged from 4% to 8% between 1994 and 1998.

HIV-1 and/or HIV-2 prevalence among sex workers in Ouagadougou and Bobo-Dioulasso increased from 17% in 1986 to 58% in 1994. Data were not available for the individual virus types. Nor were data available outside of the major urban areas among sex workers.

In 1990, 19% of male STI clinic patients tested in Bobo-Dioulasso were HIV-positive. In 1992, 42% of female STI clinic patients in Bobo-Dioulasso tested positive for HIV-1.

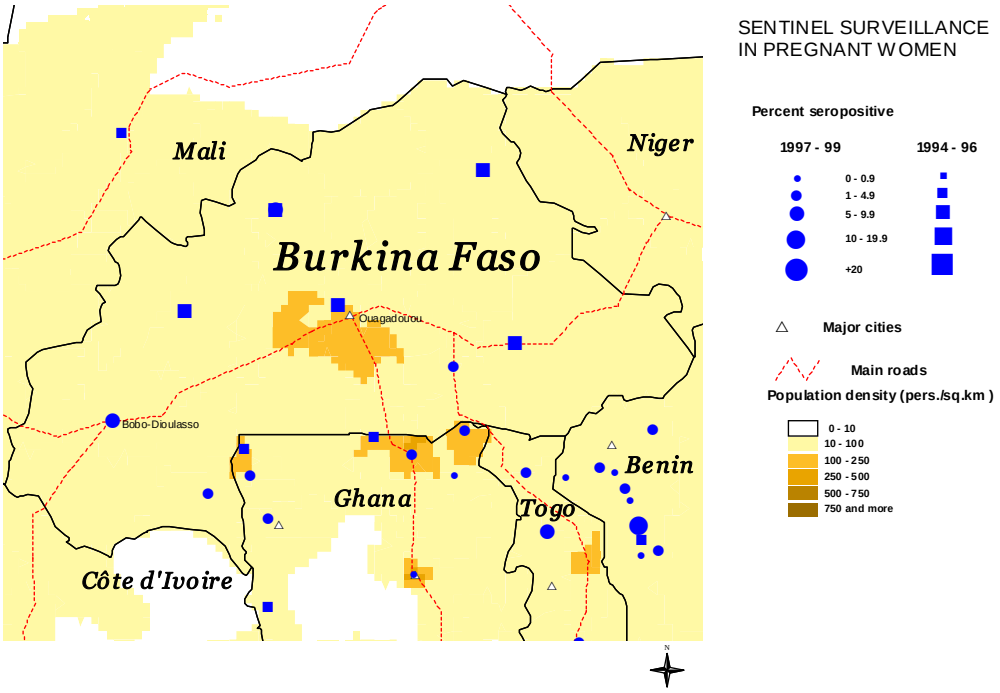
In 1994, 16% of truck drivers tested in Bobo-Dioulasso were HIV-1-infected.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	350 000	330 000	6.44	180 000	20 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	320 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	43 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1992	15–24	61.3	31.4

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	7.4	5.9	8.3



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Burkina Faso are extensive compared with other French-speaking African countries. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is average compared with other countries in sub-Saharan Africa. At the household level, AIDS expenditures are equivalent to double the GDP per capita. Individuals and families lose earning power as they face exorbitant medical costs that rapidly diminish savings. This loss in wealth is exacerbated by a decline in revenues as a result of AIDS morbidity and mortality in the agricultural sector. In the education sector, a UNAIDS/UNICEF model shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. The health sector studies show a large gap in funding required for a scaled-up care and prevention programme, equivalent to US$ 3-4 per capita and 2.4% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 0.8% by 2010 (1).

Economic impact of HIV/AIDS on households

Family payments for the lifetime care of an AIDS patient were reported to be between US$ 416 and US$ 546—equivalent to two times the per capita income in 1993 (2).

Economic impact of HIV/AIDS on agriculture

A 1997 study carried out by the Food and Agricultural Organization in Sanguié and Boulkiemdé found shifting work patterns and an overall reduction in food production as a result of coping with AIDS in the household. In the same study, a 25-50% decline in net revenues from agricultural production was observed (3).

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 700 000 primary school students, 7400 children would have lost a teacher to AIDS in 1999 (4).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: More than 50% of hospital beds are occupied by those with AIDS-related illness (5).

Resource gap: The annual costs of scaling-up HIV/AIDS programmes nationwide is estimated to be between US$ 37 million and US$ 57 million (6).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements:

Source: UNAIDS

Date: 20 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements:

Source: UNAIDS

Date: 20 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: 20 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: National AIDS Committee being restructured; decentralized structures being set up; AIDS/STI being integrated into health structures.

Source: UNAIDS

Date: 20 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: A framework for the National Response has been completed, and an operational plan 2001-2003 is nearing completion.

Source: UNAIDS

Date: 20 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Priorities defined, but not ranked.

Source: Analysis of Completed Strategic Plans, Burkina Faso, Africa Desk.

Date: 5 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements:

Source: UNAIDS

Date: 20 June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	11 616	UNPOP
Population aged 15-49 (thousands)	1999	5110	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	16	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.8	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	250	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.2	World Bank
Human Development Index rank (HDI)	2000	172	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	19	UNESCO
Adult male literacy rate	1995	30	UNESCO
Adult female literacy rate	1995	9	UNESCO
Male secondary school enrolment ratio	1996	11.7	UNESCO
Female secondary school enrolment ratio	1996	6.4	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	46	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	18	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	930	WHO
Life expectancy at birth	1998	45	UNPOP
Total fertility rate	1998	6.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	97	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	12	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	27	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	37	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Comité National de Lutte contre le SIDA/ONUSIDA. *La lutte contre le VIH/SIDA et les MST au Burkina Faso*. 1997.

(3) Food and Agricultural Organization. *The rural people of Africa confronted with AIDS: a challenge to development*. Rome, FAO, 1997.

(4) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(5) *Epidémie du VIH/SIDA au Burkina Faso: Diagnostics et Réponses Opérationnelles*. Preliminary. 4 December 2000. Ouagadougou.

(6) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Burundi

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s from Burundi. Bujumbura is considered the only major urban area in the country. From 1985–87 to 1995, HIV prevalence among antenatal women increased from 15% to 28% in Bujumbura. In 1998, 19% of antenatal clinic women tested were HIV-positive and 30% of 25–29-year-olds were HIV-positive. Outside Bujumbura, up to six sites have reported HIV prevalence among antenatal clinic women. In 1997, a median of 9% of the women tested were HIV-positive. HIV prevalence ranged from 3% to 17%. In 1998, 20% of antenatal clinic women tested in Gitega were HIV-positive, among whom 24% under 20 years of age were HIV-positive.

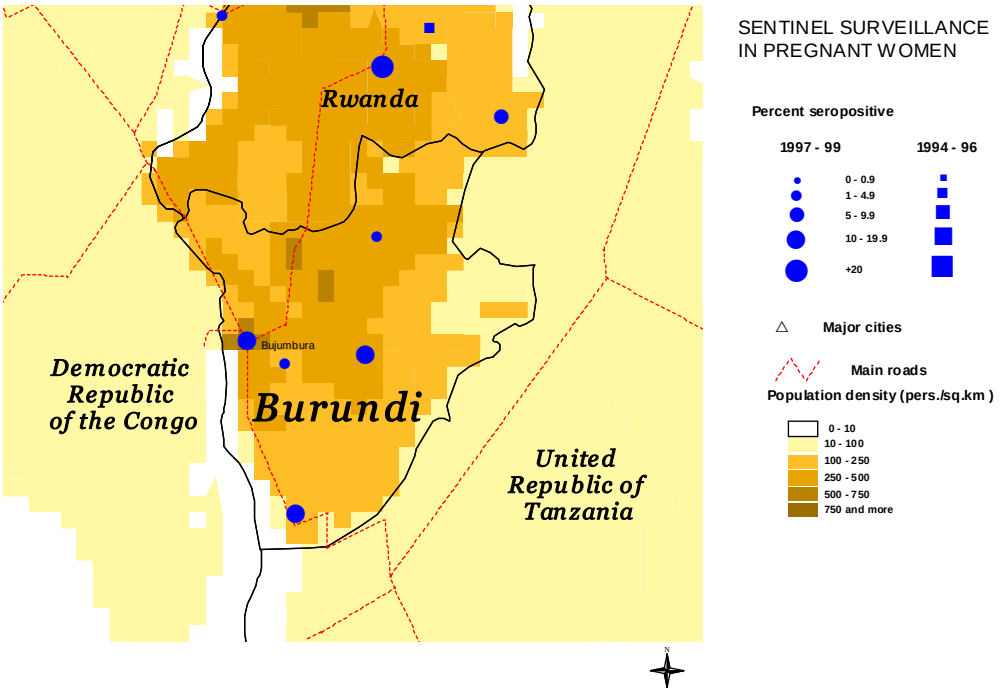
In 1993, 42% of sex workers tested in Bujumbura were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	360 000	340 000	11.32	190 000	19 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	230 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	39 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	18.6	18.6	18.6



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Burundi were found in the literature review. Two international studies using models to explore the effect of AIDS on the education and health systems provided some information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required in order for us to understand the full impact. In education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are also required in order for us to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers. One model shows that resources required to implement a scaled-up prevention and care programme represent a per capita cost of around US$ 3 to US$ 4 and 3% of GDP.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 650 000 primary school students, 9500 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 22 million and US$ 30 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements:

Source: NACP/STD

Date: 23 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports	X	
Others		

Comments/Key elements:

Source: NACP

Date: 23 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
X	

Comments/Key elements: The legislation has been submitted for the President's signature.

Source: NACP

Date: 23 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: National High Council against AIDS (Inter-Ministerial Committee)

Source: NACP

Date: 23 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements:

Source: NSP document

Date: 29 April 1999

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

Source: NSP document

Date: 29 April1999

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: The budget for the two first years was clearly established in the document but only two-fifths of it has so far been made available by different donors.

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	6565	UNPOP
Population aged 15–49 (thousands)	1999	2996	UNPOP
Annual population growth (%)	1990–1998	2.1	UNPOP
% of population urbanized	1998	8	UNPOP
Average annual growth rate of urban population (%)	1990–1998	6.2	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	140	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-1.5	World Bank
Human Development Index rank (HDI)	2000	170	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	35	UNESCO
Adult male literacy rate	1995	49	UNESCO
Adult female literacy rate	1995	23	UNESCO
Male secondary school enrolment ratio	1996	10.2	UNESCO
Female secondary school enrolment ratio	1996	6.2	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	42	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	20	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1,300	WHO
Life expectancy at birth	1998	43	UNPOP
Total fertility rate	1998	6.2	UNPOP
Infant mortality rate (per 1000 live births)	1999	116	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	9	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	24	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	50	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Cameroon

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the late 1980s from Cameroon. In Cameroon, Yaoundé and Douala are the major urban areas. HIV prevalence among antenatal women tested in the major urban areas increased from 1% in the late 1980s to 4% in 1994. In 1995, 3% of antenatal women tested in Yaoundé were HIV-positive. In 1996, 5% of antenatal women tested in Douala and Yaoundé were HIV-positive. Outside the major urban areas, HIV information is available from Bamenda, Bertoua, Garoua, Limbe, Kumba, and other areas. HIV prevalence among antenatal women tested has increased from less than 1% in 1989 to 8% in 1996. In 1996, prevalence ranged from 3% to 11%.

HIV prevalence among sex workers tested in the major urban areas increased from 6% in 1987 to nearly 30% in 1993 [HIV information for 1992 includes HIV-2]. In 1994 and 1995, 21% and 17% of sex workers tested were HIV-positive. In 1986, 1% of sex workers tested in Ngaoundéré and Nkongsamba were HIV-positive. In 1990–91, 6% of sex workers tested in Bamenda and Edea were HIV-positive. In Yaoundé, HIV prevalence among tested STI clinic patients increased from 5% in 1992 to 16% in 1996. Outside of the major urban areas, HIV prevalence among STI clinic patients tested in six sites had reached 8% in 1992. In 1994, 9% of patients tested in Banka were HIV-positive.

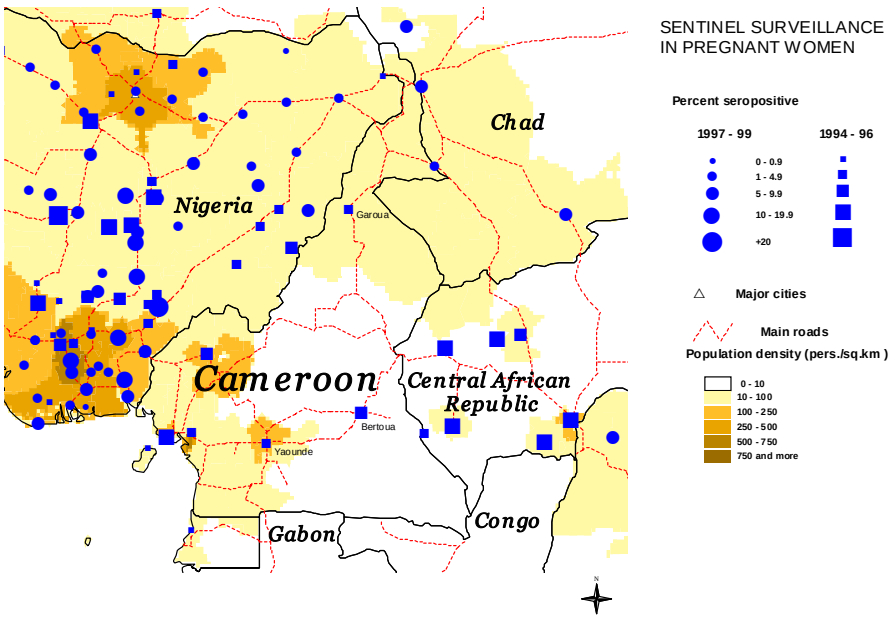
In 1993 and 1994, 15% of truck drivers tested in Douala tested positive for HIV infection. A similar study conducted in South-West and Littoral Provinces found 17% of truck drivers positive for HIV infection. In 1996, 15% of military personnel tested were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	540 000	520 000	7.73	290 000	22 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	270 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	52 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1998	15-59	6.6	-
Reported non-regular sexual partnership over a 12-month period (%)	1990	15–59	29.0	16.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	5.5	5.5	5.5



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Cameroon were found in the literature review. Only international studies using models to explore the effect of AIDS on the education and health systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. In businesses, more detailed studies are required in order for us to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. In the health sector, costs of a scaled-up response are equivalent to US$ 2–3 per capita and 0.5% of GDP. Further data are also required to show how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 830 000 primary school students, 7300 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Demand: Not available

Supply: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes nationwide are estimated to be between US$ 29 million and US$ 45 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Since July 1999, Cameroon has undertaken a process of elaborating a National Strategic Plan, which will soon be finalized. Shortly, the NACP will elaborate a specific action plan focusing on youth in an academic, military, and public service setting.

Source: UNAIDS Cameroon

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military		X
Workplace		X
Sports		X
Others		

Comments/Key elements: There exist no fully elaborated policies and strategies *per se*. On the other hand, specific actions are being taken by the following sectors: a prevention project in a rural setting, with US funding of US$ 15 000. It is being carried out by the World Bank at the initiative of the Minister of Agriculture and will affect the lives of 350 000 people in a rural setting. UNDP and WHO have, for two years now, supported the education of health professionals to treat people living with HIV/AIDS and to treat people with STIs. The NACP, in collaboration with Coopération Française, has recently taken two important initiatives in Yaoundé: the opening of a daycare hospital and the reduction of mother-to-child transmission. The project "Preventing the Sexual Transmission of HIV/AIDS in the Armed Forces and Police of Cameroon" received a subsidy from the SPDF of US$ 102 000, from 1997 to 1999. Two important private sector initiatives in Cameroon are carrying out prevention activities: the Cameroon Development Corporation (CDC) – an agro-industrial business that has 12 000 employees and is the country's second-largest employer after the State – and the Cameroon Aluminum Company (ALUCAM), which set up a HIV/AIDS prevention programme in 1996, with the help of OPALS. In June 2000, it launched a tri-therapy treatment programme called TRICAM, with contributions from the Rothschild Hospital in Paris.

Source: UNAIDS Cameroon

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Cameroon

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: The National Committee of the Fight against HIV/AIDS is a multisectoral initiative that was set up in 1986.

Source: UNAIDS Cameroon

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The National Strategic Plan was formulated for the third time in January 2000.

Source: UNAIDS Cameroon

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: The objectives and strategic priorities of the National Strategic Plan are not clearly spelled out. A mission is expected to finalize them in July 2000.

Source: UNAIDS Cameroon

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	x

Comments/Key elements: Multisectoral approach that, at present, is mainly part of the Ministry of Health, other sectors not yet being greatly involved. For the moment, as far as formulating a new strategic plan is concerned, a much larger participation of the other sectors is under way.

Source: UNAIDS Cameroon

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	14 693	UNPOP
Population aged 15–49 (thousands)	1999	6713	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	46	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.4	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	620	World Bank
GNP per capita average annual growth rate (%)	1996–1997	1.7	World Bank
Human development index rank (HDI)	2000	134	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	63	UNESCO
Adult male literacy rate	1995	75	UNESCO
Adult female literacy rate	1995	52	UNESCO
Male secondary school enrolment ratio	1996	30.3	UNESCO
Female secondary school enrolment ratio	1996	20.6	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	39	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	550	WHO
Life expectancy at birth	1998	55	UNPOP
Total fertility rate	1998	5.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	72	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990-1999	19	UNICEF/UNPOP
% of births attended by trained health personnel	1990-1999	58	UNICEF
% of one-year-old children fully immunized-DPT	1995-1998	46	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Cape Verde

HIV/AIDS epidemiological summary

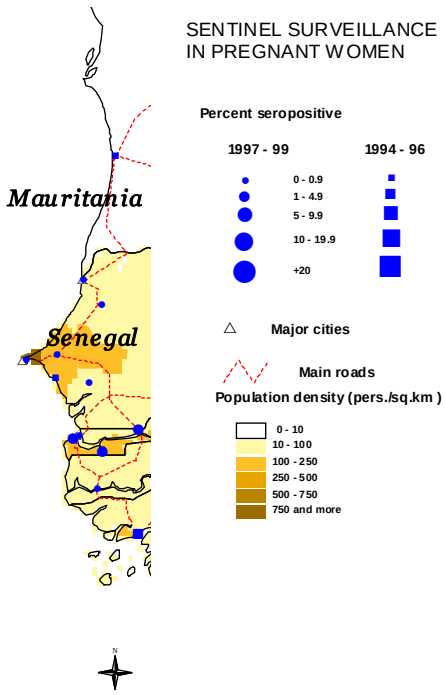
No recent sentinel surveillance data are available. In the major urban area of Praia, HIV prevalence in 15–55-year-olds was 1.4% in 1988. In a study of sex workers in several Cape Verde islands, HIV prevalence was 2% in 1987. In all prevalence studies in the 1980s, only HIV-2 (and no HIV-1) was detected.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	-	-	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Not available

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: The National AIDS Control Programme has a policy and strategy component on HIV/AIDS and STIs.

Source: NACP

Date: 18 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace		X
Sports		X
Others, prisons and immigration	X	

Comments/Key elements: There is a document on prevention among young people. Although there is no specific document concerning the military and private-for-profit sectors, they are both very involved in the national response.

Source: NACP

Date: 18 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: No specific legislation beyond the legal documents on public health protection and health promotion.

Source: NACP

Date: 18 July 2000

Organizational structure

Existence of high-level structure in support of the national response

Yes	No
X	

Comments/Key elements: There exists a multisectoral commission on HIV/AIDS, composed of line ministries, donors and international organizations. The NACP is the main coordinator of the national response. It is collaborating with several projects and programmes, such as the Reproductive and Sexual Health project.

Source: NACP

Date: 18 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Situation and response analyses have been done. The strategic plan is under preparation.

Source: NACP

Date: 18 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Country priorities are already identified: STI control, mother-to-child transmission, surveillance, access to drugs, care. They will constitute the core of the national strategic plan.

Source: NACP

Date: 18 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: The strategic plan is under preparation.

Source: NACP

Date: 18 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	417	UNPOP
Population aged 15–49 (thousands)	1999	216	UNPOP
Annual population growth (%)	1995-2000	2.3	UNPOP
% of population urbanized	1998	61	UNPOP
Average annual growth rate of urban population (%)	1995-2000	2.8	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1998	1200	UNDP
GNP per capita average annual growth rate (%)	1990-1998	2.2	UNDP
Human Development Index rank (HDI)	2000	105	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1998	72.9	UNDP
Adult male literacy rate	1998	83.7	UNDP
Adult female literacy rate	1998	64.6	UNDP
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	1997	35.5	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	32	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	6	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	55	UNDP
Life expectancy at birth	1999	69	UNPOP
Total fertility rate	1999	3.6	UNPOP
Infant mortality rate (per 1000 live births)	1999	5.6	UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized (DTP)	-	-	-

References

Central African Republic

HIV/AIDS epidemiological summary

HIV surveillance information on antenatal clinic women has been available from the Central African Republic since the mid-1980s. In Bangui, considered the major urban area in the Central African Republic, HIV prevalence among antenatal clinic women remained relatively stable between 1986 and 1990, ranging from 5% to 7%. HIV prevalence began to increase in 1994, when 9% of antenatal clinic women tested positive for HIV. In 1996, the HIV prevalence rate was 12%. HIV prevalence among antenatal women by age is only available from one site in Bangui in 1990. Nearly 8% of women less than 20 years of age tested positive for HIV and nearly 21% of women 25–29 years of age tested HIV-positive.

Outside Bangui, we have also had data for antenatal clinic women since the mid-1980s. HIV prevalence had remained relatively stable in these sites ranging from 5% to 8% up through 1993. Similar to trends in Bangui, in 1994, the median HIV prevalence among antenatal clinic women from nine sentinel sites increased to 10% and further increased to 14% in 1996. HIV prevalence by age is only available for 1990. Ten per cent of women less than 20 years of age tested HIV-positive.

HIV prevalence among sex workers in Bangui ranged from 14% to 20% in the mid-to-late 1980s. No further information is available for this group.

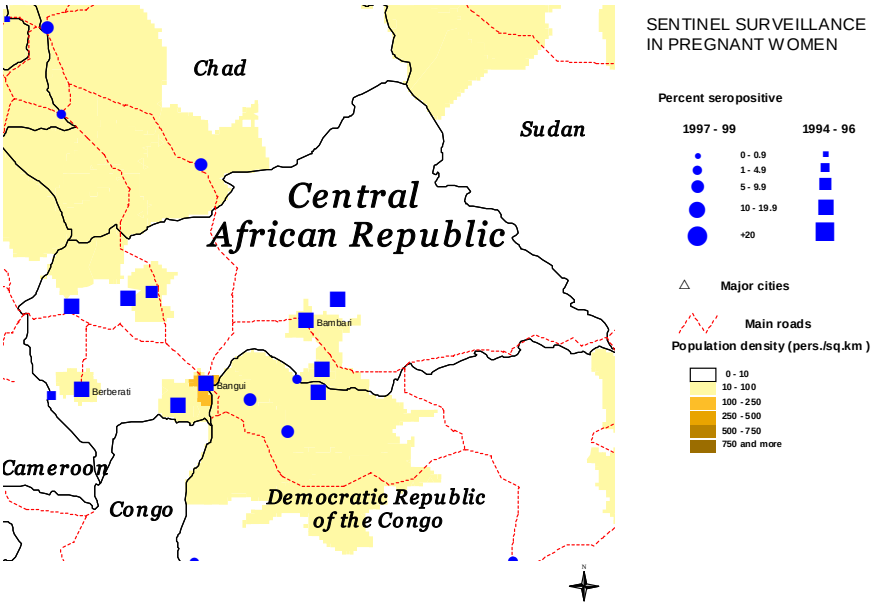
In Bangui, HIV prevalence among STI clinic patients tested increased from 14% in 1989 to 25% in 1995. Between 1994 and 1996 outside of Bangui, 30–40% of STI clinic patients tested were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	240 000	230 000	13.84	130 000	8900

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	99 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	23 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1995	15-49	22.7	10.7

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	12.8	10.8	15.2



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Central African Republic were found in the literature review. Two international studies using models to explore the effect of AIDS on the education and health systems provided information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. It also shows that enrolment rates for AIDS orphans are lower than those for the general school age population. Studies are also required to understand how the epidemic is impacting on demand and supply in the health sector. One model shows that resources required to implement a scaled-up prevention and care programme represent a per capita cost of around US$ 3 to US$ 5 and 1.7% of GDP.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 330 000 primary school students, 5700 would have lost a teacher to AIDS in 1999 (2). Between 25% and 50% of teachers are expected to die of AIDS by 2005 (1).

Demand: The current school enrolment rates of 56% as compared with 39% for orphans (1).

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Annual costs of scaling-up HIV/AIDS programmes estimated to be between US$ 12 million and US$ 17 million (3).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: MTP II terminates in 1999, when a new strategic plan will be developed.

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military	X	
Workplace		X
Sports	X	
Others: Ministries of Social Affairs, Communication, and Civil Service; Justice; Planning & Finance.	X	

Comments/Key elements: The multisectoral policy is just being translated into action.

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: There is a national committee, and various other committees exist to take up specific issues, but none of them actually functions fully yet.

Source: UNAIDS

Date: July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Plan 1995-1999.

The proposal for an interim plan is awaiting the establishment of a new strategic plan.

Source: Interim Plan

Date: April 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:
Interim Plan: Promotion of lower risk sexual behaviour; diagnostic treatment of STI; MTCTP: taking over treatment of the ill; formulation of a new strategic plan; and evaluation of MTP II.
Source: Interim Plan 2000-2002

Date: April 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: No budget was announced in the Interim Plan. MTCT is being financed by UNAIDS. Elaboration of strategic plan contributed by UNAIDS. Care of the sick: FSTI.

Source: UNAIDS

Date: July 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	3550	UNPOP
Population aged 15–49 (thousands)	1999	1640	UNPOP
Annual population growth (%)	1990–1998	2.1	UNPOP
% of population urbanized	1998	39	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.8	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	320	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.6	World Bank
Human Development Index rank (HDI)	2000	166	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	60	UNESCO
Adult male literacy rate	1995	69	UNESCO
Adult female literacy rate	1995	52	UNESCO
Male secondary school enrolment ratio	1996	13.9	UNESCO
Female secondary school enrolment ratio	1996	5.8	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	19	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	700	WHO
Life expectancy at birth	1998	45	UNPOP
Total fertility rate	1998	4.9	UNPOP
Infant mortality rate (per 1000 live births)	1999	97	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	15	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	46	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	46	UNICEF

References

(1) World Bank. *Malawi AIDS Assessment Study*, #10, 1998. Washington D.C., World Bank.

(2) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(3) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Chad

HIV/AIDS epidemiological summary

In the major urban area of N'Djaména, HIV prevalence among antenatal clinic attendees increased from 2% of women tested in 1995 to 6% in 1999. Outside of N'Djaména, a median of 5% of antenatal clinic women tested HIV-positive in Abéché, Bol, Bongor, and Sarh in 1999.

In 1995, 13% of commercial sex workers tested in N'Djaména were HIV-positive. Also, 10% of military personnel tested in N'Djaména were HIV-positive.

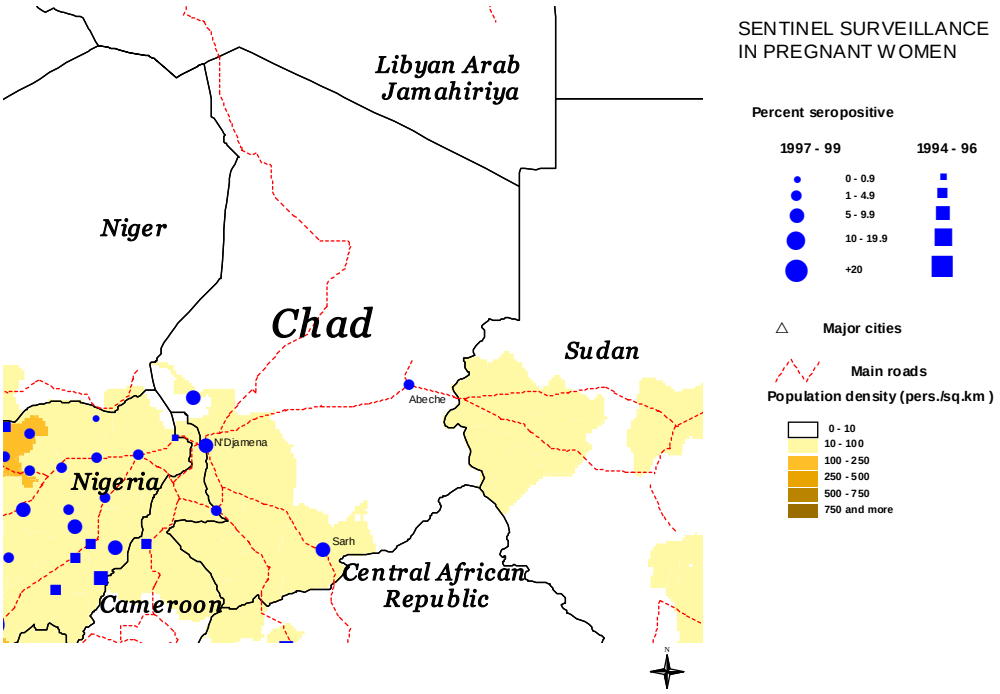
Among STI clinic patients tested in Bol and Faya, 22% were HIV-positive in 1999.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	92 000	88 000	2.69	49 000	4000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	68 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	10 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1999	6.2	3.6	7.3



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Chad were found in the literature review. Only one international study using a model to explore the effect of AIDS on the education systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. With over 85% of the GDP generated through agriculture, these effects can have a severe impact on output and food security. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are also needed in order for us to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 700 000 primary school students, 2600 would have lost a teacher to AIDS in 1999.

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: policy formulated in the MTP I and II. Currently the NSP 1999–2003 is being finalized.

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education		
Health	X	
Military	X	
Workplace		
Sports		
Others		

Comments/Key elements: Eleven Ministries have formulated AIDS projects.

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	x

Comments/Key elements: The parliamentary network for population and development has initiated a study on current legislation and the institutional and judicial framework as it relates to HIV/AIDS.

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

1. The national AIDS committee (line ministries and main partners).
2. The technical AIDS Committee (DG of line ministries and experts)
3. The NACP

This structure is currently being reorganized

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: the 1999–2003 NSP is being finalized.

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

- Strengthening of advocacy at all levels, catalytic projects and multisectoral response.
- Partnership
- Focus on vulnerable groups
- Better knowledge of the epidemic
- Effective care of infected persons
- Contractual approach
- Decentralization
- Involvement of religious organizations
- Strengthening of the activities in the key ministries

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: A budget has been drafted for the NSP 1999–2003. A mobilization meeting for resources was organized in March 1999, outside of the sectoral round table for health. For 1999–2000, finance has been almost exclusively received from IDA, GT, UNDP, WHO, EU, and Chad Government funds.

Source: UNAIDS Focal Point Chad

Date: 1 July 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	7458	UNPOP
Population aged 15–49 (thousands)	1999	3283	UNPOP
Annual population growth (%)	1990–1998	2.9	UNPOP
% of population urbanized	1998	22	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.7	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	230	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.5	World Bank
Human Development Index rank (HDI)	2000	167	UNDP
% population economically active	1993	43.9	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	48	UNESCO
Adult male literacy rate	1995	62	UNESCO
Adult female literacy rate	1995	35	UNESCO
Male secondary school enrolment ratio	1996	16.2	UNESCO
Female secondary school enrolment ratio	1996	4.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	43	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1500	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	6.0	UNPOP
Infant mortality rate (per 1000 live births)	1999	110	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	4	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	15	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	24	UNICEF

References

Comoros

HIV/AIDS epidemiological summary

There was no evidence of HIV infection among antenatal clinic women in Moroni, the major urban centre, between 1991 and 1996.

In 1994, 57% of sex workers tested in Moroni were HIV-positive.

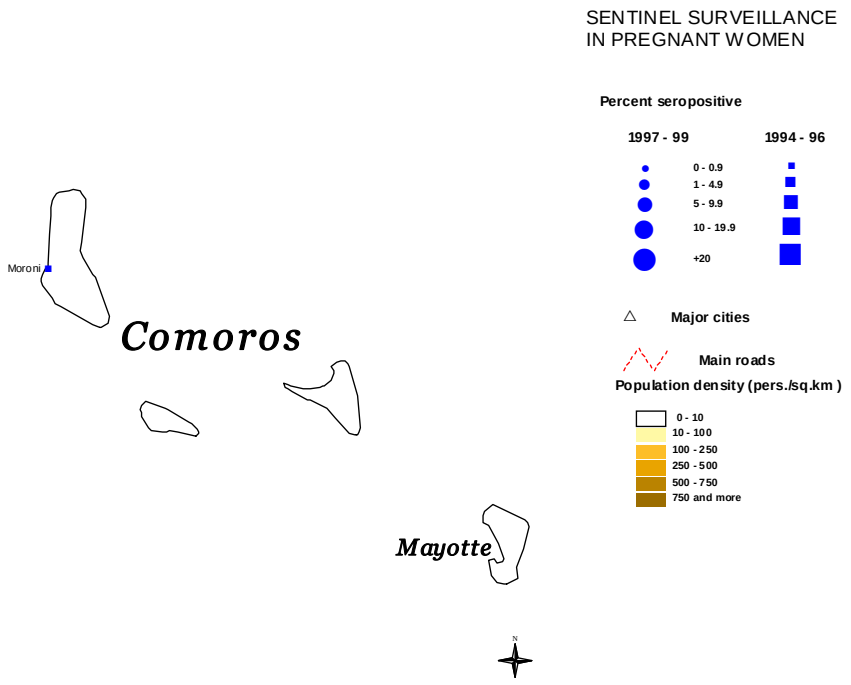
There was no evidence of HIV infection among STI patients tested in 1987 or in 1996.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	400	0.12	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1996	0.0	0.0	0.0



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Comoros were found in the literature review. However, if the epidemic develops in the same way as it has in many African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required in order for us to understand the full impact. In education, a model developed by UNAIDS and UNICEF shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further studies are required to show how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: However, there is a National Programme for the Fight against STD/AIDS, with an Action Plan, 1999–2003.

Source: NACP

Date: 11 March 1999

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: There are Programmes in the Ministry of Education, Ministry of Health, and the Armed Forces.

Source: NACP

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: NACP

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

Yes	No
X	

Comments/Key elements: The National Committee for the Fight against AIDS has been in place since 28 October 1988, and is composed of an Inter-Ministerial Committee and a Multisectoral Committee. It is not operational.

Source: NACP

Date: 1990

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Not available

Source: NACP

Date: March 1990

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: In collaboration with other partners: WHO/UNICEF/UNFPA/EU/Coop. Française.

Source: NACP

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements*:* The NACP does not have its own functioning budget but functions on an ad hoc basis according to the availability of resources from its donors and partners.

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	676	UNPOP
Population aged 15-49 (thousands)	1999	327	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	31	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.8	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1998	370	UNDP
GNP per capita average annual growth rate (%)	1990-1998	-3.0	UNDP
Human development index rank (HDI)	2000	137	UNDP
% population economically active	-	45.0	ILO
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	57	UNESCO
Adult male literacy rate	1995	64	UNESCO
Adult female literacy rate	1995	50	UNESCO
Male secondary school enrolment ratio	1996	23.1	UNESCO
Female secondary school enrolment ratio	1996	21.2	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	36	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	9	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	950	WHO
Life expectancy at birth	1998	59	UNPOP
Total fertility rate	1998	4.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	74	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	21	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	52	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	75	UNICEF

References

Congo

HIV/AIDS epidemiological summary

HIV surveillance information on antenatal clinic women has been available from the Congo since the late 1980s. Brazzaville and Pointe Noire are considered the major urban areas. In these areas, HIV prevalence among antenatal clinic women increased from around 5% in the late 1980s to 8% in 1994. Outside the major urban areas, HIV prevalence among antenatal clinic women initially appeared to be similar to that seen in the major urban areas. However, with increasing numbers of sites reporting, HIV prevalence in 1993 was found to be 4% among women tested.

In 1987, nearly 50% of sex workers in the major urban areas tested positive for HIV. No further information is available for this group.

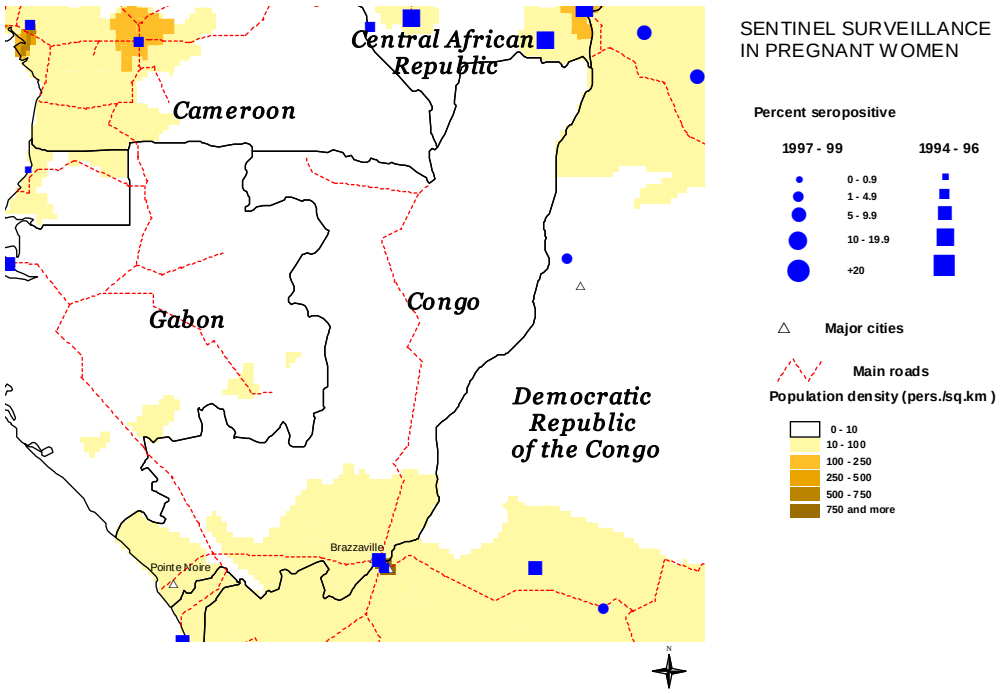
Limited information is available on HIV prevalence among STI clinic patients. In Brazzaville 1990, 16% of male and 20% of female STI clinic patients tested positive for HIV.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	86 000	82 000	6.43	45 000	4000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	53 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	8600	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1994	7.5	6.0	8.0



Economic Impact of HIV/AIDS

Summary of economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Congo were found in the literature review. Only one international study using a model to explore the effect of AIDS on the education systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required for an understanding of the full impact. The education model, developed by UNAIDS and UNICEF, shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are also required for an understanding of how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 450 000 primary school students, 3900 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: Not available

Source: Focal Point UNAIDS

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education	X	
Health	X	
Military	X	
Workplace		X
Sports		X
Others		X

Comments/Key elements: Not available

Source: Focal Point UNAIDS

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
X	

Comments/Key elements:

Source: Ref. Droits, Devoirs, et Principes dans l'action contre l'épidémie du VIH/SIDA, "Déclaration de Brazzaville" (WHO, NAP, OHCHR, and UNDP).

Date: 2 December 1995

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: The multisectoral National Committee for the Fight against HIV/AIDS (Le Comité National de Lutte contre le VIH/SIDA) existed from 1987 to 1997 but has not been reactivated since the end of the war.

Source: Focal Point UNAIDS

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Existence of the NACP

Source: Focal Point UNAIDS

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:
- Prevention of sexual transmission
- Prevention of maternal transmission to the fetus
- Prevention of transmission through breastfeeding

Source: Focal Point UNAIDS

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements:

- Budget ONUSIDA:	US$ 100 000
- Budget OMS:	US$ 47 000
- Budget Ambassade de France:	FF 20 000
- Budget Government:	CFA 30 000 000

Source: Focal Point UNAIDS

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	2864	UNPOP
Population aged 15-49 (thousands)	1999	1270	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	59	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.1	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	670	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-2.7	World Bank
Human development index rank (HDI)	2000	139	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	75	UNESCO
Adult male literacy rate	1995	83	UNESCO
Adult female literacy rate	1995	67	UNESCO
Male secondary school enrolment ratio	1996	60.0	UNESCO
Female secondary school enrolment ratio	1996	43.3	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	43	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	890	WHO
Life expectancy at birth	1998	49	UNPOP
Total fertility rate	1998	6.0	UNPOP
Infant mortality rate (per 1000 live births)	1999	89	UNICEF/UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	1995–1998	23	UNICEF

References

Côte d'Ivoire

HIV/AIDS epidemiological summary

HIV-1 prevalence information among antenatal clinic attendees has been available since the mid-1980s from Côte d'Ivoire. In Côte d'Ivoire, Abidjan is considered the major urban area. In 10 years, HIV-1 prevalence among antenatal women increased from 3% in 1986 to 14% in 1995. In 1998, 11% of antenatal clinic women tested in one site were HIV-positive. Five per cent of the women less than 20 years of age were HIV-1-positive. In 1997, the median HIV prevalence among antenatal clinic women from nine sites outside Abidjan was 10%, ranging from 6% to 13%. Seven per cent of tested antenatal clinic attendees less than 20 years of age were HIV-positive. The peak age group was the 20–24-year-old group with 12% of clinic attendees testing HIV-positive.

HIV-1 prevalence among sex workers tested in Abidjan increased from 27% in 1986 to over 84% in 1992–93. In 1994–95, nearly 70% of sex workers tested were HIV-1-positive. In Odiénné, HIV-1 prevalence among sex workers tested increased from 37% in 1987 to 53% in 1990. In a separate study conducted in five regions in 1987, 34% of sex workers tested were HIV-1- and/or HIV-2-positive.

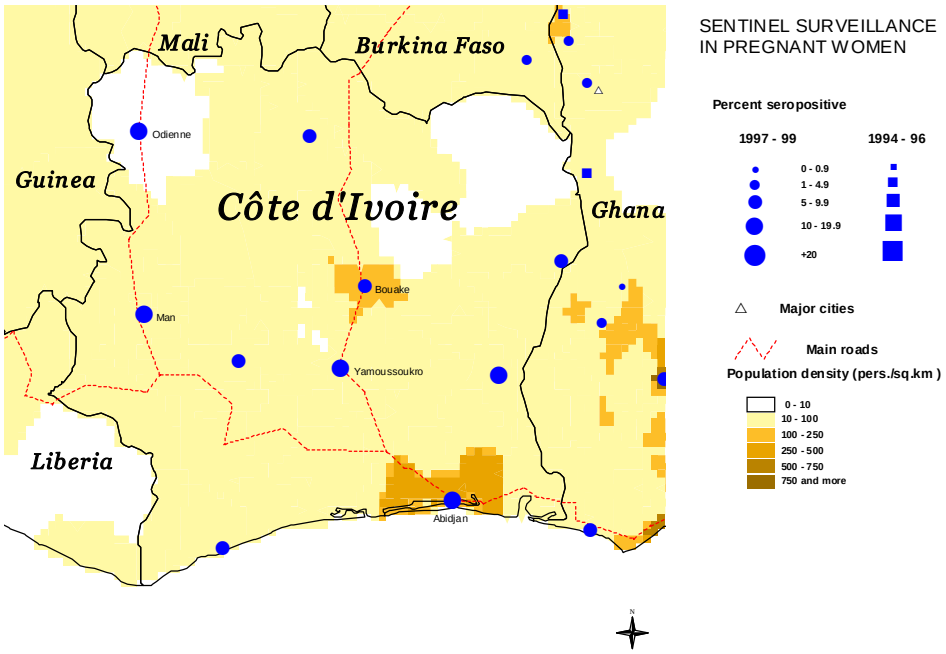
In Abidjan, 1987, 8% of STI clinic attendees tested positive for HIV-1 and/or HIV-2. HIV-1 prevalence increased from 17% to 18% of male STI clinic patients tested between 1990 and 1992. A small study of male STI patients, conducted outside Abidjan in 1987, reported HIV-1 and/or HIV-2 prevalence of 35%. Information by virus type was not available.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	760 000	730 000	10.76	400 000	32 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	420 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	72 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1993	15–19	24.0	4.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	10.6	10.6	10.6



Economic Impact of HIV/AIDS

Summary of economic impact of HIV/AIDS

Compared to many other sub-Saharan African countries, data on the economic impact on Côte d'Ivoire are relatively extensive. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is average for sub-Saharan Africa. A household survey carried out in the mid-1990s shows a dramatic impact on wealth in households affected by AIDS. This impact is exacerbated in rural areas, where tending for the sick leads to shifts in production patterns from cash crops to food. In the business sector, available data show the extent to which urban businesses can be handicapped by this disease. In the public sectors, especially education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. The health sector is having to cope with hospitals where over 40% of beds are occupied by patients with AIDS-related illness and yet there are still extensive investments required to scale-up AIDS programmes equivalent to US$ 2-3.5 per capita and 0.5% of GDP.

Macro-economic impact

Preliminary results of a model developed in 2000 estimate the loss in GDP growth per capita as a result of AIDS to be 0.8% (1).

Economic impact of HIV/AIDS on households

Empirical data collected in a 1996 study show that, following an AIDS death, average household consumption falls 44% on the previous year and households with an AIDS patient spend twice as much on medical expenses as those without (2). In the mid-1990s, the average expenditure required to care for a male AIDS patient was 25% of annual net income in the North and 50% of annual net income (US$ 300) in the Mid-West (2).

Economic impact of HIV/AIDS on agriculture

In 1997, it was found that one method for coping with HIV/AIDS was switching to food versus cash crops, as a result of which production was reduced to two-thirds of previous levels (3).

Economic impact of HIV/AIDS on firms

Supply: A survey of three firms in Abidjan showed average annual costs per employee due to HIV ranging from 0.8% to 3.2% of the wage bill in 1997 (4). Another survey of four businesses found total medical costs of between 146 million and 298 million FCFA in 1993 (5).

Economic impact of HIV/AIDS on education

Supply: In 1996/7 and 1997/8, 64% and 70% of teachers' deaths of known causes were HIV-related (6); a model developed by UNAIDS and UNICEF in 2000 shows that, of around 1.7 million primary school students, 23 000 children would have lost a teacher to AIDS in 1999 (7).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: 41% of all hospital beds in Abidjan were occupied by AIDS patients in 1997 (8). By 1997, AIDS-related costs absorbed 11% of the total public health system budget (9).

Resource gap: The annual costs of scaling-up HIV/AIDS programmes nationwide are estimated to be between US$ 34 million and US$ 55 million (10).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: The national strategic plan is the only document used as the basis of the national response.

Source: UNAIDS

Date: 20 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Based on impact studies. Specific sectoral policies are under development.

Source: UNAIDS

Date: 20 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: The existing legislation will suffice, if applied.

Source: UNAIDS

Date: 20 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: The creation of a permanent structure attached to the Office of the Prime Minister or the Ministry of Planning is being explored.

Source: UNAIDS

Date: 20 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: National strategic plan for the period 2000–2004

Source: UNAIDS

Date: 20 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Plan stratégique national de lutte contre le SIDA, 2000–2004, Ministry of Health, Programme National de Lutte contre le SIDA, Abidjan.

Source: UNAIDS

Date: 20 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: The national strategic plan does not suggest costs. International aid is frozen. Only the UN system supports the national programme.

Source: UNAIDS

Date: 20 June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	14 526	UNPOP
Population aged 15-49 (thousands)	1999	6807	UNPOP
Annual population growth (%)	1990–1998	2.6	UNPOP
% of population urbanized	1998	44	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.7	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	710	World Bank
GNP per capita average annual growth rate (%)	1996–1997	4.3	World Bank
Human development index rank (HDI)	2000	154	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	40	UNESCO
Adult male literacy rate	1995	50	UNESCO
Adult female literacy rate	1995	30	UNESCO
Male secondary school enrolment ratio	1996	32.6	UNESCO
Female secondary school enrolment ratio	1996	15.5	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	810	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	5.0	UNPOP
Infant mortality rate (per 1000 live births)	1990	85	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	15	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	47	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	61	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Bechu, N. The impact of AIDS on the economy of families in Côte d'Ivoire: Changes in consumption among AIDS-affected households. In: Ainsworth, M., Fransen, L., Over, M., editors. *Confronting AIDS: Evidence from the developing world*: Selected Background papers for the World Bank Policy Research Report. European Commission: United Kingdom, 1998.

(3) Black. *Impact du VIH/SIDA sur les systèmes d'exploitation agricoles en Afrique de l'Ouest*. Rome, FAO, 1997.

(4) Aventin, L., Huard, P. HIV/AIDS and manufacturing in Abidjan. *AIDS Analysis Africa* 1997; **7**(3).

(5) Kone, T. et al. *L'impact économique du SIDA dans les entreprises privées à Abidjan*. 1994.

(6) UNAIDS et al. Le VIH/SIDA et le Corps des Enseignants: Santé du Personnel Enseignant. Bulletin No.3. 1998. Projet: Impact du VIH/SIDA sur le système éducatif Ivoirien et suivi des objectifs de l'éducation primaire pour tous.

(7) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(8) *"HIV/AIDS Country Profiles: Cote d'Ivoire." AIDS Analysis Africa* 1997 Apr.; **7**(2).

(9) Centre International de l'enfance et de la famille. *SIDA et Secteur de Santé: Analyse des conséquences et stratégies de réponse*. 1997. Côte d'Ivoire, Ministère de la Santé Publique et des Affaires Sociales de la Côte d'Ivoire.

(10) World Bank and UNAIDS. Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa. Draft report, April 2000.

Democratic Republic of the Congo

HIV/AIDS epidemiological summary

HIV information from among antenatal clinic attendees has been available from the Democratic Republic of the Congo since the mid-1980s. Over the 15-year period 1985 to 1999, the median HIV prevalence rate among antenatal clinic women in Kinshasa, the major urban area, fluctuated between 3% and 7%. In 1999, 4% of antenatal clinic attendees tested were HIV-positive. Prevalence ranged from 3% to 5%. Sentinel surveillance outside of Kinshasa is infrequent. A few studies conducted in Kananga, Likasi, Lubumbashi, Musoshi, Kimpese and Kasumbalesa have shown that HIV prevalence among antenatal women tested ran 3-4% between 1988 and 1993. In 1997, HIV testing was conducted at 14 sites. Four per cent of antenatal clinic women tested HIV-positive, with prevalence ranging from 1% to 6%. In Lubumbashi, 1999, 9% of antenatal clinic women tested were HIV-positive.

Between 1985 and 1997, HIV prevalence among sex workers in Kinshasa fluctuated between 27% and 38% among those women tested. There is limited HIV information on sex workers outside of Kinshasa. A study conducted in Haute-Zaire in 1991 reported that 25% of sex workers tested were HIV-positive. In 1997, 29% of sex workers tested in Mbuji-Mayi were HIV-positive.

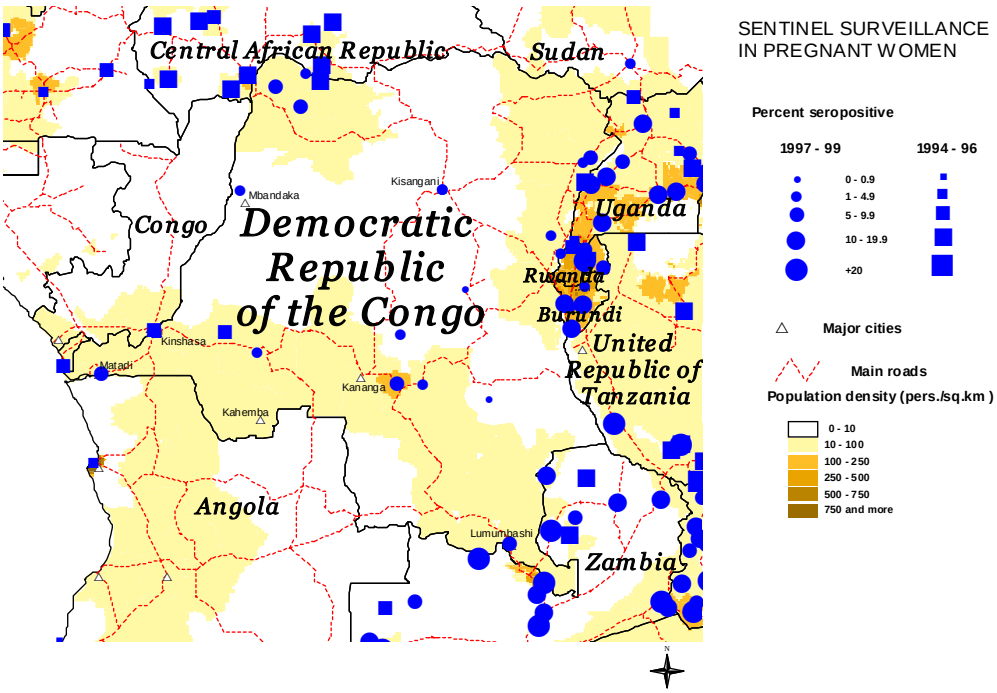
There is very little information available about HIV prevalence among STI clinic patients. In 1997, 12% of STI clinic patients tested in Kinshasa and 8% of STI clinic patients tested in Mbuji-Mayi were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	1 100 000	1 100 000	5.07	600 000	53 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	680 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	95 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1993	15–19	24.0	4.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1999	4.1	2.7	5.4



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in the Democratic Republic of the Congo are limited. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is average for sub-Saharan Africa. Data from the 1980s show that the impact on wealth at the household level is significant. No data were found for the impact on the agricultural or business sectors. However, it is likely that the increased costs and shifting production patterns are leading to reduced net revenues in agriculture as a result of AIDS and that businesses are already facing rising costs in order to cover employees' AIDS-related medical and funeral expenses. In the public sectors, the education study shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. The health sector is coping with hospitals where over 50% of beds are occupied by patients with AIDS-related illness and yet there are still extensive investments required to scale-up AIDS programmes equivalent to US$ 1-2 per capita and 1.7% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the decline in GDP per capita growth as a result of AIDS by 2010 to be 0.7% (1).

Economic impact of HIV/AIDS on households

A survey of 33 families in the late 1980s found that the average expenditure on a hospital stay for a child was US$ 90 for a child with AIDS, which compares with the average monthly income of US$ 30 (2); a separate study in the same time period found that, on average, the costs of AIDS for an adult prior to hospitalization and subsequent funeral costs were US$ 109 and US$ 320 respectively (3).

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 830 000 primary school students, 7300 would have lost a teacher to AIDS in 1999 (4).

Demand: Not available

Economic impact on the health sector

Demand: The percentage of hospital beds occupied by people living with HIV/AIDS was 50% at Mama Yemo Hospital, Kinshasa in 1995 (5).

Supply: 6.4% and 8.7% of employees at Mama Yemo Hospital were HIV-positive in 1984 and 1986 respectively, reflecting a two-year incidence rate of 3.2% (6).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 66 million and US$ 105 million (7).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Not available

Source: NACP/STD, 1999-2008

Date: 1999

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military		X
Workplace		X
Sports		X
Others		

Comments/Key elements: Not available

Source: UNAIDS DRC

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS DRC

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A multi-sectoral body exists, the National Committee for the Fight against AIDS, presided over by the Minister of Health.

Source: UNAIDS DRC

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
x	

Comments/Key elements: Both a strategic plan and a Master Triennial Plan, 1999–2001, exist.

Source: UNAIDS DRC

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: The Master Plan gives widely defined directives at many levels.

Source: UNAIDS DRC

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: The budget is widely underestimated.

Source: UNAIDS DRC

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	50 335	UNPOP
Population aged 15-49 (thousands)	1999	21 513	UNPOP
Annual population growth (%)	1990–1998	3.4	UNPOP
% of population urbanized	1998	29	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.7	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	110	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-8.6	World Bank
Human development index rank (HDI)	2000	152	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	77	UNESCO
Adult male literacy rate	1995	87	UNESCO
Adult female literacy rate	1995	68	UNESCO
Male secondary school enrolment ratio	1996	36.8	UNESCO
Female secondary school enrolment ratio	1996	22.8	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	46	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	14	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	870	WHO
Life expectancy at birth	1998	51	UNPOP
Total fertility rate	1998	6.4	UNPOP
Infant mortality rate (per 1000 live births)	1999	87	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	8	UNICEF/UNPOP
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	1995–1998	10	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Davachi, F. et al. The economic impact of families of children with AIDS in Kinshasa, Zaire. In: Fleming, A. F. et al, editors. *The Global Impact of AIDS*. New York, Alan R Liss, 1988.

(3) Hassig, S. E. et al. An analysis of the economic impact of HIV infection among patients at Mama Yemo Hospital, Kinshasa, Zaire. *AIDS* 1990; **4**:883-7.

(4) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(5) The World Bank. *Confronting AIDS: Public Priorities in a Global Epidemic*. New York, NY: Oxford University Press, 1997.

(6) N'Galy, B. et al. Human Immunodeficiency Virus infection among employees in an African hospital. *New England Journal of Medicine* 1988; 319(17): 1123-7.

(7) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Djibouti

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Djibouti since 1991. HIV prevalence increased among antenatal clinic attendees tested from less than 1% in 1991 to 4% in 1993. In 1995, 9% of antenatal clinic women tested were HIV-positive. However, in 1996, only 3% of women tested were HIV-positive.

Information on HIV prevalence among sex workers has been available since the late 1980s. HIV prevalence among sex workers tested has ranged from 26% to 37% between 1991 and 1998. According to the National AIDS Control Programme, in 1998, 28% of sex workers tested were HIV-positive.

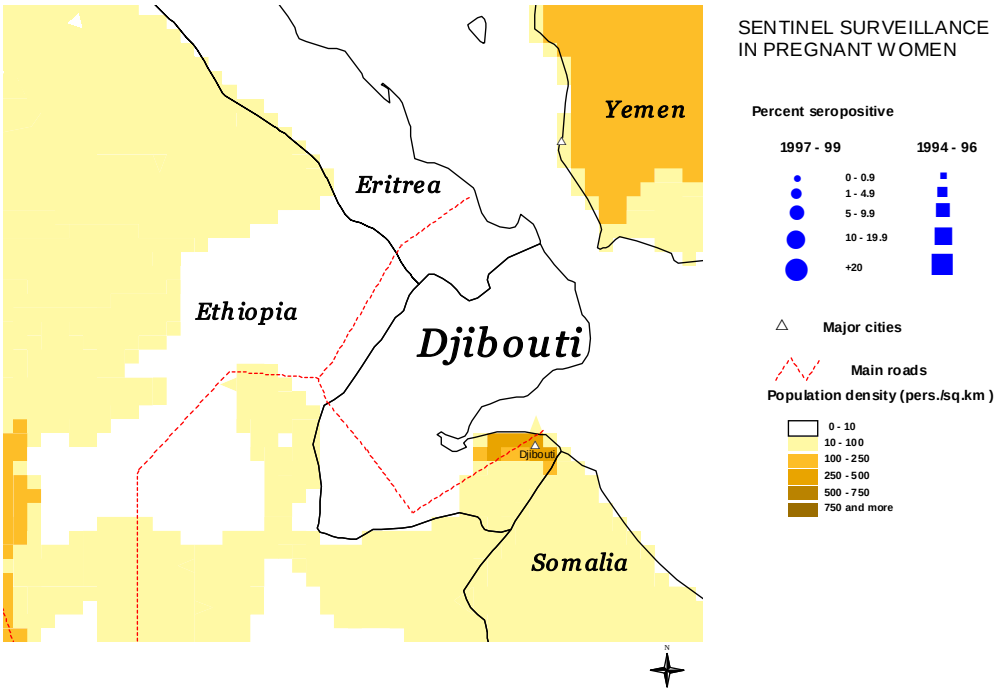
HIV prevalence among STI clinic patients tested increased from 1% in 1987 to 22% in 1996.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	37 000	35 000	11.75	19 000	1500

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	7200	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	3100	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent Intercourse with a non-regular partner (%)	1995	15–49	71.7	67.4
Reported non-regular sexual partnership over a 12-month period (%)	1995	15–49	19.0	5.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1996	2.86	2.86	2.86



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Djibouti were found in the literature review. Only one international study using a model to explore the effect of AIDS on the education systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. The education study shows that increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are also required for an understanding of how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 40 000 primary school students, 500 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: However, a Mid-Term Action Plan was utilized in 1994-1997 and is still used as a point of reference.

Source: UNAIDS Focal Point

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: A National AIDS Control Programme (NACP) was set up in 1987 and continues to exist in (among other ways) the form of a permanent structure associated with the Ministry of Health.

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: In 1996, UNDP recruited consultants to formulate an ethical and juridical code dealing with HIV/AIDS. That report exists and is currently being updated by the NACP, in collaboration with UN agencies. It will be submitted for approval.

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A National AIDS Committee exists, but is not functional.

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: However, a Mid-Term Plan of Action from 1994 to 1997 is still in use today.

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: Despite the absence of a national strategy, the Government, in collaboration with UNAIDS and Theme Groups, has identified priorities, e.g., focusing on STI, disseminating information and raising awareness among students and non-students, focusing on pregnant women, focusing on psycho-social aspects.

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: A budget exists to support HIV/AIDS prevention programmes; however, it is insufficient to meet the need. This is compounded by the fact that the country is currently under structural budgetary restrictions.

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	629	UNPOP
Population aged 15-49 (thousands)	1999	295	UNPOP
Annual population growth (%)	1990–1998	2.3	UNPOP
% of population urbanized	1998	82	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.6	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	-	-	-
GNP per capita average annual growth rate (%)	-	-	-
Human development index rank (HDI)	2000	149	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	46	UNESCO
Adult male literacy rate	1995	60	UNESCO
Adult female literacy rate	1995	33	UNESCO
Male secondary school enrolment ratio	1996	16.6	UNESCO
Female secondary school enrolment ratio	1996	11.6	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	15	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	570	WHO
Life expectancy at birth	1998	51	UNPOP
Total fertility rate	1998	5.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	104	UNPOP/UNICEF
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	1990–1999	79	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	23	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

Egypt

HIV/AIDS epidemiological summary

HIV testing has been conducted among antenatal clinic women in Egypt since the late 1980s. HIV testing in Cairo and Alexandria up through 1996 found no evidence of HIV infection among antenatal clinic women. Nor was there evidence of HIV infection among antenatal women tested in Aswan in 1992 and 1993.

Similarly, no evidence of HIV infection was found among sex workers tested in the major urban areas of Cairo (1990–91) and Alexandria (1993), or among sex workers tested in an unspecified area in 1992, and 1994 through 1999, except in 1996 where 0.7% of sex workers tested were found to be HIV-positive.

A study among IV drug users in Cairo, 1994, found nearly 8% of them tested positive for HIV, but those tested between 1995 and 1999 showed no evidence of HIV infection.

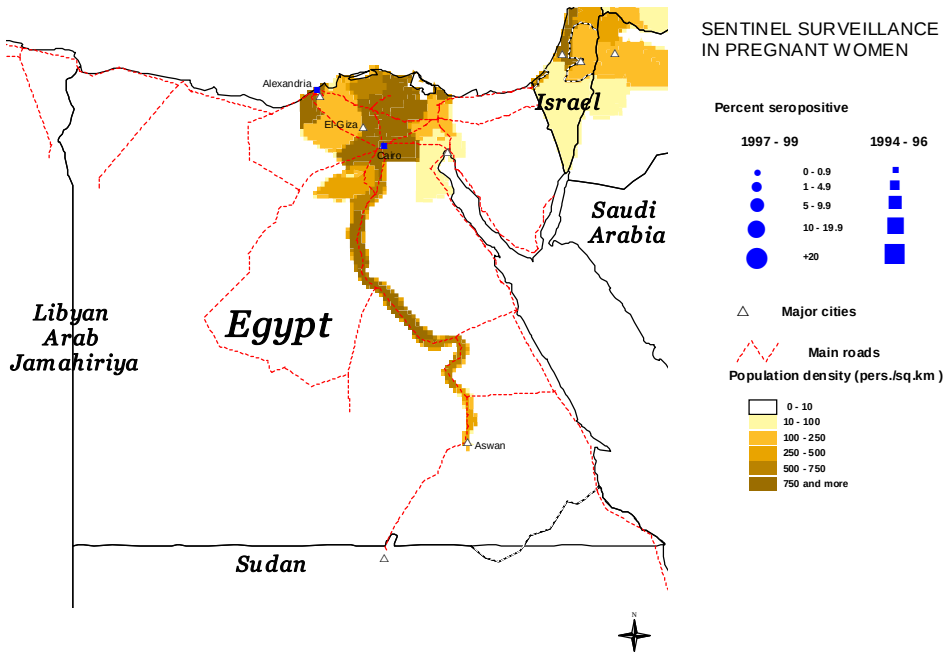
In Alexandria and Cairo, less than 1% of male STI clinic patients tested were HIV-positive in 1988 and 1990, while, similarly, very little evidence of HIV infection was found among STI clinic patients tested in Alexandria, Cairo and an unspecified area, 1991–1999. In only one site in Cairo, 1993, 0.3% of STI clinic patients tested were HIV-positive. In 1992 and 1993, HIV testing among STI clinic patients in Asyut found no evidence of HIV infection.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	8100	0.02	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Egypt were found in the literature review. However, if the epidemic develops in the same way as with many African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Demand: Not available

Supply: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	67 226	UNPOP
Population aged 15–49 (thousands)	1999	34 411	UNPOP
Annual population growth (%)	1990–1998	1.9	UNPOP
% of population urbanized	1998	45	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.1	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1997	1200	World Bank
GNP per capita average annual growth rate (%)	1996–1997	4.5	World Bank
Human development index rank (HDI)	2000	119	UNDP
% population economically active	1995	29.9	ILO
Unemployment rate	1995	11.3	ILO
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	51	UNESCO
Adult male literacy rate	1995	64	UNESCO
Adult female literacy rate	1995	39	UNESCO
Male secondary school enrolment ratio	1996	80.1	UNESCO
Female secondary school enrolment ratio	1996	70.2	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	26	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	7	UNPOP
Maternal mortality rate (per 100 000 live births)	-	170	WHO
Life expectancy at birth	1998	67	UNPOP
Total fertility rate	1998	3.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	47	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	55	UNICEF
% of births attended by trained health personnel	1990–1999	56	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	96	UNICEF

References

Equatorial Guinea

HIV/AIDS epidemiological summary

Very little information on HIV prevalence is available for Equatorial Guinea. A 1992 study of antenatal clinic women in urban areas found 2% of women tested positive for HIV infection. In 1996, 1% of antenatal clinic women tested in Malabo and Bata were HIV-positive. In the insular area of the country, 0.3% of antenatal clinic women tested positive for HIV infection in 1995.

There is no information on HIV prevalence among sex workers.

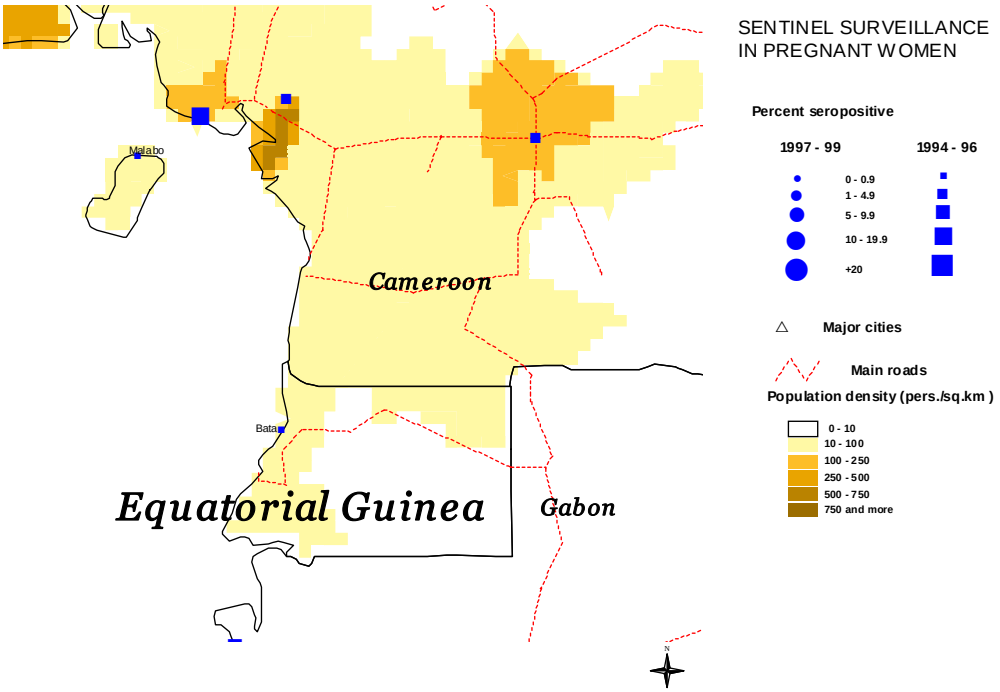
In 1992 and 1993, 6% of STI clinic patients tested were HIV-positive. In 1996, 3% of patients tested in Malabo and 29% of patients tested in Bata were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	1100	1000	0.51	560	<100

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	860	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	120	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1996	0.7	0.4	1.0



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Equatorial Guinea were found in the literature review. However, if the epidemic moves in the same direction as with many African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes **No**

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes **No**

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes **No**

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes **No**

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes **No**

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	442	UNPOP
Population aged 15–49 (thousands)	1999	199	UNPOP
Annual population growth (%)	1990–1998	2.5	UNPOP
% of population urbanized	1998	44	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.9	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1998	1110	UNDP
GNP per capita average annual growth rate (%)	1990-1998	14.8	UNDP
Human development index rank (HDI)	2000	131	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	79	UNESCO
Adult male literacy rate	1995	90	UNESCO
Adult female literacy rate	1995	68	UNESCO
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	-	-	-
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	41	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	820	WHO
Life expectancy at birth	1998	50	UNPOP
Total fertility rate	1998	5.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	105	UNICEF/UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	-	-	-

References

Eritrea

HIV/AIDS epidemiological summary

In 1994, 3% of antenatal clinic attendees from a non-specified geographic region tested positive for HIV infection. No other information is available for this population group.

There is some limited information on HIV prevalence among sex workers. In 1988, 2% tested in Asmara were HIV-positive. The rate increased to 6% in 1989. Also in 1988, a median of 3% of sex workers in Assab, Keren, and Massawa tested HIV-positive, the range running from 1% in Massawa to 32% in Assab. In 1994, 25% of sex workers tested in an unspecified geographic area were HIV-positive.

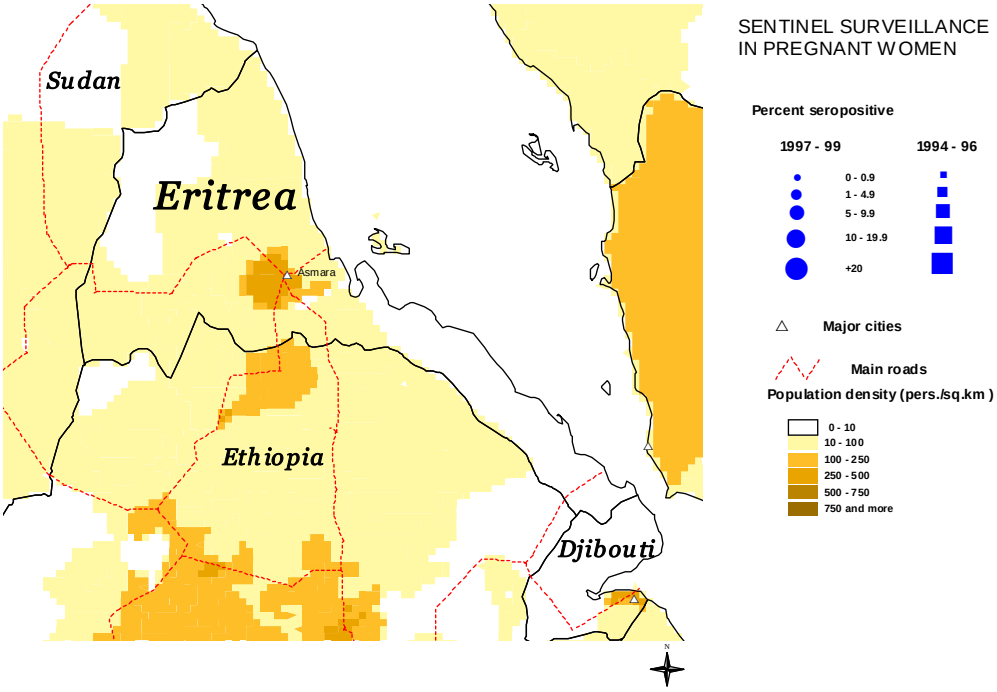
In 1994,10% of STI clinic patients tested in a non-specified geographic region were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	49 000	2.87	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	UNAIDS/WHO, June 2000
Estimated AIDS deaths	-	-	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1995	15–49	29.0	9.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Eritrea were found in the literature review. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. A model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are also required to show how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements:

Source: National AIDS Control Programme (NACP)

Date: 1998

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports		
Others	X	

Comments/Key elements:

Source: NACP

Date: 1998

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
X	

Comments/Key elements:

Source: NACP

Date: 1998

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: Inter-Ministerial Committee

Source: NACP

Date: 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Plan needs updating and is not fully implemented.

Source: NACP

Date: 1997

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

Source: NACP

Date: 1997

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements:

Source: NACP

Date: 1997

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	3719	UNPOP
Population aged 15-49 (thousands)	1999	1704	UNPOP
Annual population growth (%)	1990–1999	2.7	UNPOP
% of population urbanized	1998	17	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.6	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1998	200	UNDP
GNP per capita average annual growth rate (%)	-	-	-
Human development index rank (HDI)	2000	159	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1998	52	UNDP
Adult male literacy rate	-	-	-
Adult female literacy rate	1998	38	UNDP
Male secondary school enrolment ratio	1996	24.0	UNESCO
Female secondary school enrolment ratio	1996	17.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	40	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	14	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	1400	WHO
Life expectancy at birth	1998	51	UNPOP
Total fertility rate	1998	5.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	87	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	8	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	21	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	60	UNICEF

References

Ethiopia

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Ethiopia since 1989. In Addis Ababa, the major urban area, HIV prevalence increased among tested antenatal clinic attendees from 5% to 20% between 1989 and 1993. In 1997, 18% of antenatal clinic women tested in Addis were HIV-positive. Outside Addis Ababa, limited information is available. In 1991, a median of 5% of antenatal clinic attendees tested in Dire Dawa and Metu were HIV-positive. In 1993, 4% of antenatal clinic attendees tested at 10 sites were HIV-positive. In 1998, a median of 9% of antenatal clinic women tested were HIV-positive.

Information on HIV prevalence among sex workers in Addis Ababa has been available since the mid-1980s. However, there is very little new information. In Addis Ababa, less than 1% of sex workers tested in 1985 were HIV-positive. By 1990, HIV prevalence among sex workers tested in Addis Ababa had reached 54%. Outside Addis Ababa, information on HIV prevalence among sex workers is available from 19 sites in 1988. HIV prevalence among sex workers tested in these sites ranged from 5% to 38%. In 1998, 17% of sex workers tested in 22 sites were HIV-positive. HIV prevalence ranged from 1% in Masawa to 38% in Dessie.

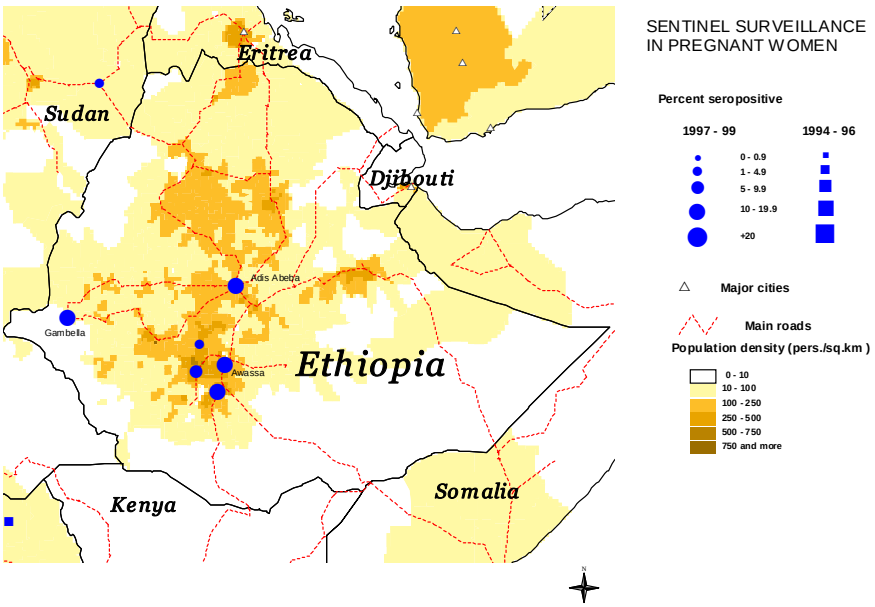
There is some limited information available on HIV prevalence among STI clinic patients from Addis Ababa. HIV prevalence increased from 8% to 38% between 1987 and 1992. HIV prevalence among female STI clinic patients increased from 8% to 37% between 1987 and 1989. There is no recent information from this group. In 1985–86, about 0.1% of military recruits tested HIV-positive. In 1991, 3% of military recruits tested were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	3 000 000	2 900 000	10.63	1 600 000	150 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	1 200 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	280 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1994	15–49	47.9	47.7
Reported non-regular sexual partnership over a 12-month period (%)	1994	15–49	18.2	5.2

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	17.6	14.1	20.0



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Ethiopia are relatively extensive when compared with many countries in sub-Saharan Africa. Preliminary results of a recently developed model on the macroeconomic impact of AIDS shows that the impact is slightly lower than the average for this region. At the household level, HIV/AIDS is having a real impact on wealth, with average treatment and mourning costs exceeding average farm incomes. This is exacerbated by the reduced time spent on agricultural activities in an AIDS-afflicted household. Firms are having to meet the cost of increasing medical and funeral expenses due to AIDS-related illness. In education, a model developed by UNAIDS and UNICEF shows that increasing mortality rates due to AIDS have led to discontinuity in teaching with many pupils losing or having a change in their teachers. The health sector is coping with hospitals where an increasing percentage of beds are occupied by patients with AIDS-related illness and yet there are still extensive investments required to scale-up AIDS programmes: equivalent to $US 2–US$ 2.5 per capita and 2.4% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the loss in GDP growth per capita as a result of AIDS to be 0.6% by 2010 (1).

Economic impact of HIV/AIDS on households

A 1993 study of 25 households found that the average cost of treatment, funeral and mourning is several times the average income: the average net farm income was found to be 270–620 birr (US$ 324–744) compared to mean expenditures on treatment of 1930 birr (US$ 2316) and on funerals of 327 birr (US$ 392) (2).

Economic impact of HIV/AIDS on agriculture

In a survey carried out in 1994, the mean number of hours per week in agriculture per household was found to be 33.6 hours in non-AIDS-afflicted household as compared with between 11.6 and 16.4 hours in those that were afflicted (3).

Economic impact of HIV/AIDS on firms

Supply: In a recent survey of 15 firms, AIDS accounted for 53% of all illness incidences over a 5-year period (4).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 4.3 million primary school students, 51 000 would have lost a teacher to AIDS in 1999 (5).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: In 1994, bed occupancy due to AIDS was predicted to increase to 28% by 2005 (6).

Resource gap: The annual cost of scaling-up HIV/AIDS activities nationwide is estimated at US$ 112 million to US$ 156 million (7).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Written in August 1998 both in English and Amharic.

Source: UNAIDS

Date: 22 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: The general National HIV/AIDS Policy covers all sectors. None of the sectors, however, has its own specific HIV/AIDS Policy.

Source: UNAIDS

Date: 22 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: The whole penal code has been revised and the draft revised penal code document is to be discussed at a forthcoming workshop. Note that sub-articles 8.2-8.6 of the National HIV/AIDS Policy speak about HIV/AIDS and Human Rights. Sub-article 10.1 specifically mentions that relevant laws shall be instituted to enforce the Policy. Specific legislation against wilful transmission of infections exists. HIV, however, is not specifically mentioned.

Source: UNAIDS

Date: 22 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: National AIDS Council since April 2000

Source: UNAIDS

Date: 22 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Federal and National HIV/AIDS Strategic Plans

Source: UNAIDS

Date: 22 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: The coming Joint Mission on HIV/AIDS was to look at this aspect of the plan in July 2000.

Source: UNAIDS

Date: 22 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Budget and costing need to be refined. Again this will be looked at by the coming Joint UNAIDS Mission as part of its terms of reference.

Source: UNAIDS

Date: 22 June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	61 095	UNPOP
Population aged 15–49 (thousands)	1999	27 201	UNPOP
Annual population growth (%)	1990–1998	2.7	UNPOP
% of population urbanized	1998	16	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.2	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	110	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.0	World Bank
Human development index rank (HDI)	2000	171	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	36	UNESCO
Adult male literacy rate	1995	46	UNESCO
Adult female literacy rate	1995	25	UNESCO
Male secondary school enrolment ratio	1996	13.0	UNESCO
Female secondary school enrolment ratio	1996	10.3	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	44	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	20	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1400	WHO
Life expectancy at birth	1998	43	UNPOP
Total fertility rate	1998	6.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	113	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	4	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	8	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	58	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Demeke, M. *The potential impact of HIV/AIDS on the rural sector of Ethiopia*. 1993. Unpublished.

(3) Baryoh, A. *Socio-economic impact of HIV/AIDS on women and children in Ethiopia*. UNDP. Addis Ababa. 2000. Unpublished.

(4) Bersufekad, A. *A study on the socio-economic impact of HIV/AIDS on the industrial labour force in Ethiopia*. 1994. Unpublished.

(5) Government of Malawi and UNICEF. *Workplan and Terms of Reference for the Country Programme (1997-2001) Mid Term Review*. Malawi, Goverment of Malawi; UNICEF, 1999.

(6) Kello, A. B. *Economic impact of AIDS and its impact on the health care service system*. Unpublished report, 1994.

(7) World Bank and UNAIDS. Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa. Draft report, April 2000.

Gabon

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s from Gabon. In Libreville, the major urban area, HIV prevalence among antenatal women tested increased from 1% in 1988 to 4% in 1995. Outside Libreville, HIV prevalence information is available from Franceville in 1986, 1987, and 1989-90; from South-eastern Gabon in 1987–88; and from Estuaire in 1993. One per cent of antenatal clinic women tested HIV-positive.

There is no information available on HIV prevalence among sex workers.

In the late 1980s, 2%–4% of STI clinic patients tested in Libreville were HIV-positive. In 1996–97, 17% of STI patients in Libreville, Franceville, Moanda and Port-Gentil tested HIV-positive.

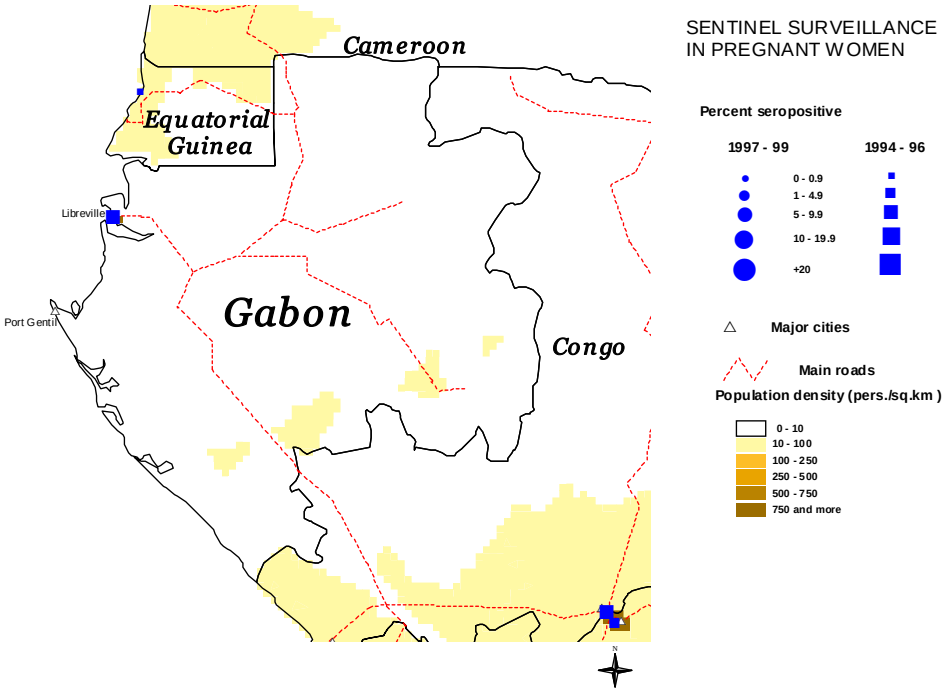
In 1997, 6% of military personnel in Port-Gentil tested HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	23 000	22 000	4.16	12 000	780

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	8600	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	2000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1995	4.0	2.1	5.4



Economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Gabon were found. However, if the epidemic develops at the same pace here as it has in many African nations, the impact will be felt in most sectors. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS leads to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Summary of the economic impact of HIV/AIDS

Not available

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: MTP II is valid until the end of 2000

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements: Not available

Source: UNAIDS

Date: July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A decree was recently adopted on the creation and organization of an Inter-Ministerial Committee, chaired by the Prime Minister.

Source: UNAIDS

Date: July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X (MTP2)	

Comments/Key elements: In addition, the country is currently developing a new strategic plan.

Source: UNAIDS

Date: July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: Only the first stage of the strategic planning process (the situation analysis) is currently being completed.

Source: UNAIDS

Date: July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: No budget ready at this stage

Source: UNAIDS

Date: July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	1197	UNPOP
Population aged 15–49 (thousands)	1999	528	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	51	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.3	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1997	4120	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.3	World Bank
Human Development Index rank (HDI)	2000	123	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	63	UNESCO
Adult male literacy rate	1995	74	UNESCO
Adult female literacy rate	1995	53	UNESCO
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	-	-	-
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	500	WHO
Life expectancy at birth	1998	52	UNPOP
Total fertility rate	1998	5.4	UNPOP
Infant mortality rate (per 1000 live births)	1999	86	UNICEF/UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	1990–1999	80	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	54	UNICEF

References

Gambia

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since 1990 from the Republic of the Gambia. Banjul is considered the major urban area in the Gambia. HIV prevalence increased from 0.1% in 1990 to 1% of antenatal clinic women tested in 1997. In four sites outside Banjul, HIV prevalence ranged from 1% to 4% of antenatal clinic women tested in 1997.

HIV prevalence among sex workers in Banjul has increased from nearly 2% in 1988–89 to 14% in 1993.

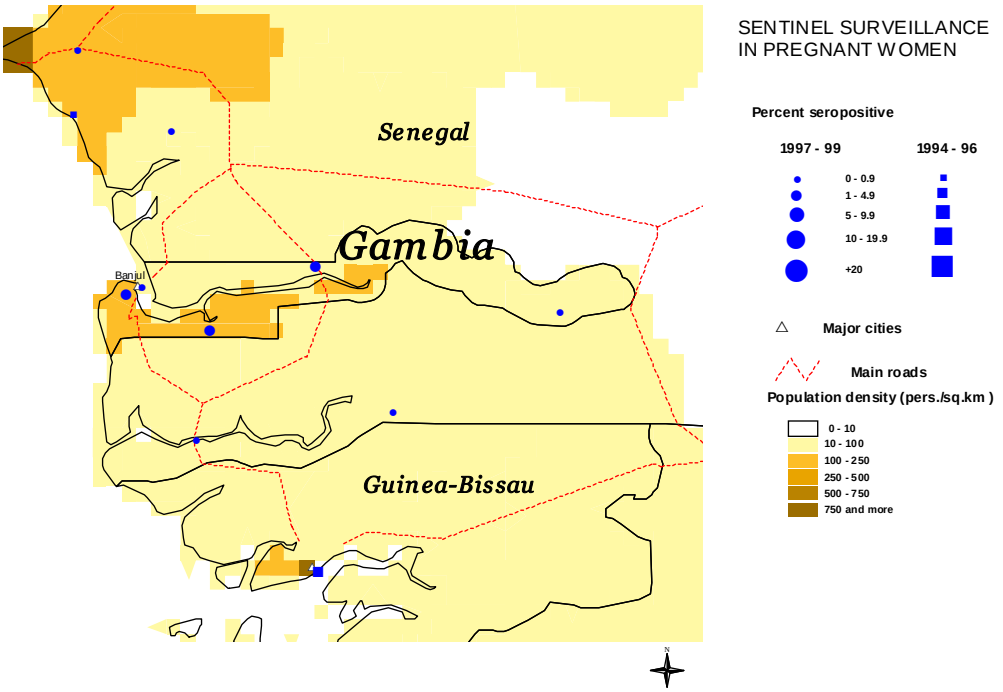
Among male STI clinic patients in Banjul, HIV prevalence increased from 1% of patients tested in 1988–90 to nearly 5% in 1991. Among female STI clinic patients tested in 1991, 4% tested HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	13 000	12 000	1.95	6600	520

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	9600	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	1400	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	1.0	1.0	1.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of AIDS in the Gambia were found in the literature review carried out. However, a recent modelling exercise calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 7 million and US$ 10 million. This represents a per capita cost of around US$ 6 to US$ 8 and 2.5 % of GDP. In education, a model developed by UNAIDS and UNICEF shows that increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Likewise, the potential impact on agriculture and rural areas, shown in other African nations to increase household expenditure, reduce savings and shift productivity patterns, should be carefully controlled, given the high dependence of the economy on the agricultural sector, comprising 30% of GDP. Although no data were available on the impact on the tourist industry, the importance of tourism to the economy of Gambia cannot be overestimated. This area should be monitored in future studies of the impact of the epidemic.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 140 000 primary school students, 353 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 7 million and US$ 10 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: National AIDS Control Programme. Policies and guidelines on HIV/AIDS, Ministry of Health, March 1995.

The following key strategic elements were adopted: testing, intensification of IEC, condom use promotion, safe blood provision, advocacy through opinion leaders, mobilization of specific groups, provision of STIs services.

Source: Department of State for Health

Date: March 1995

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace		X
Sports	X	
Others (youth)	X	

Comments/Key elements: HIV/AIDS/STI and other reproductive health issues are key components of the Population and Family Life Education being taught at school countrywide. Teachers have been specially trained to teach the subject, which is now as examinable as English, biology and mathematics.

The National Youth Policy and Action Programme was ratified in 1999, followed by the creation of a National Youth Council in January 2000. HIV/AIDS and reproductive and sexual health issues are addressed by both documents.

Source: WHO, Gambia

Date: 5 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: WHO, Gambia

Date: 5 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	x

Comments/Key elements: The National AIDS Committee is chaired by the Director of Medical and Health Services. There are moves to create a Commission or to upgrade the committee to be under the Office of the President.

Source: WHO, Gambia

Date: 5 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: No composite strategic plan (UNAIDS type) exists. But the various action plans contain strategic interventions to prevent the spread of HIV/AIDS.

Source: WHO, Gambia

Date: 5 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: However, priority issues are the following: Information-Education-Communication for the prevention of further spread of HIV; blood screening; creating a multisectoral National Programme; care and social support, including the creation of a supportive environment.

Source: WHO, Gambia

Date: 5 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: The National Budget allocates a small amount to the prevention of HIV/AIDS – e.g., emoluments for the personnel, and some supplies.

Source: WHO, Gambia

Date: 5 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	1268	UNPOP
Population aged 15–49 (thousands)	1999	613	UNPOP
Annual population growth (%)	1990–1998	3.6	UNPOP
% of population urbanized	1998	29	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.1	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	340	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.1	World Bank
Human Development Index rank (HDI)	2000	161	UNDP
% population economically active	1993	33.3	ILO
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	39	UNESCO
Adult male literacy rate	1995	53	UNESCO
Adult female literacy rate	1995	25	UNESCO
Male secondary school enrolment ratio	1996	31.9	UNESCO
Female secondary school enrolment ratio	1996	17.8	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	40	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1100	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	5.2	UNPOP
Infant mortality rate (per 1000 live births)	1999	119	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	12	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	44	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	96	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNIADS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Ghana

HIV/AIDS epidemiological summary

HIV surveillance information on antenatal clinic women has been available in Ghana since 1990. Information is available only from Accra in 1990, but, by 1994, 20 sentinel surveillance sites were reporting HIV prevalence. The rate among pregnant women slowly increased between 1990 and 1998. There are three sites that are included as the major urban areas: Accra (two reporting sites in 1997), Kumasi and Tamale. HIV prevalence among antenatal clinic women tested increased from 1% in 1990 to 3% in 1998. In 1998, HIV prevalence ranged from 2% to 7%. Outside of the major urban areas, HIV prevalence also increased, from 1% in 1991 to 3% in 1998. In 1998, HIV prevalence among the 14 sites ranged from 2% to 12%.

HIV prevalence rates among sex workers increased from 2% in 1986 to nearly 40% in 1991. By 1997, HIV prevalence among sex workers tested in Accra had reached 73%.

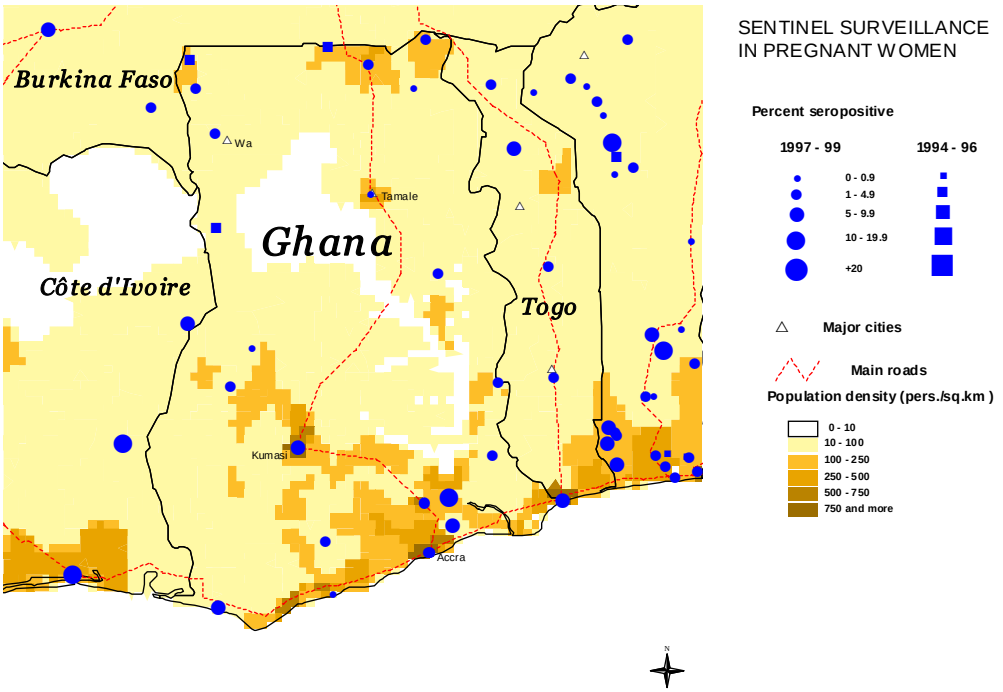
HIV prevalence among STI clinic patients in Accra increased from 2% in 1988 to nearly 9% in 1991. In 1998, HIV infection among female STI patients tested in Adabraka, Greater Accra region, had reached 27%.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	340 000	330 000	3.60	180 000	14 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	170 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	33 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	3.4	2.2	6.6



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact on Ghana are limited. Of the sectors explored here, the studies in health demonstrate that there is a large gap in funding to meet the full needs of a scaled-up care and prevention programme, which would cost approximately 1.3% of GDP. The current primary school enrolment is 43%. Although this figure is already low compared with other developing countries, AIDS could reduce it still further. A model developed by UNAIDS and UNICEF in 2000 shows that increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. The potential impact on other sectors, including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, must be carefully monitored.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 2.4 million primary school students, 11 000 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: 1995 study for the Ministry of Health estimates AIDS-related bed occupancy to be 50% in 2000 and over 90% in 2010 (2).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes nationwide is estimated to be between US$ 55 million and US$ 87 million (3).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
x	

Comments/Key elements: Draft National HIV/AIDS & STI Policy Documents, produced by the National AIDS and STD Control Programme, was due for completion in August 2000.

Supported by UNAIDS at the beginning, currently supported by USAID Policy Project.

Source: UNAIDS

Date: 26 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		x
Education		x
Health	X	
Military	X	
Workplace	X	
Sports		X
Others		X

Comments/Key elements:

Source: UNAIDS

Date: 26 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: 26 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: The National AIDS Commission being developed will be chaired by the President.

Source: UNAIDS

Date: 26 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: Expected to be finalized at the end of July.

Source: UNAIDS

Date: 26 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: The following priorities are identified in the document currently being finalized: Youth, decentralization, sex workers, women, PLWA, STIs.

Source: UNAIDS

Date: 26 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	NA

Comments/Key elements:

Source: UNAIDS

Date: 26 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	16 678	UNPOP
Population aged 15–49 (thousands)	1999	9150	UNPOP
Annual population growth (%)	1990–1998	3.0	UNPOP
% of population urbanized	1998	36	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.6	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	390	World Bank
GNP per capita average annual growth rate (%)	1996–1997	1.7	World Bank
Human Development Index rank (HDI)	2000	129	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	65	UNESCO
Adult male literacy rate	1995	76	UNESCO
Adult female literacy rate	1995	54	UNESCO
Male secondary school enrolment ratio	1996	37.8	UNESCO
Female secondary school enrolment ratio	1996	24.0	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	9	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	740	WHO
Life expectancy at birth	1998	60	UNPOP
Total fertility rate	1998	5.1	UNPOP
Infant mortality rate (per 1000 live births)	1999	64	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	22	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	39	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	68	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) Asamoah-Odei, E., Antwi, P., and Dickerson, D. *AIDS in Ghana*. Accra, Ghana, National AIDS/STD Control Programme. Ministry of Health. 1995.

(3) World Bank and UNAIDS. Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa. Draft report, April, 2000.

Guinea

HIV/AIDS epidemiological summary

Some information on HIV prevalence has been available for Guinea since the mid-1980s. In Conakry, the major urban area, between 1% and 2% of antenatal clinic women tested positive for HIV-1 and/or HIV-2 between 1986 and 1996. In 1996, from six sites outside Conakry, a median of 15 of antenatal clinic women tested positive for HIV-1 and/or HIV-2. Information on the individual viruses was not available.

In 1994, 37% of sex workers tested in Conakry were HIV-positive.

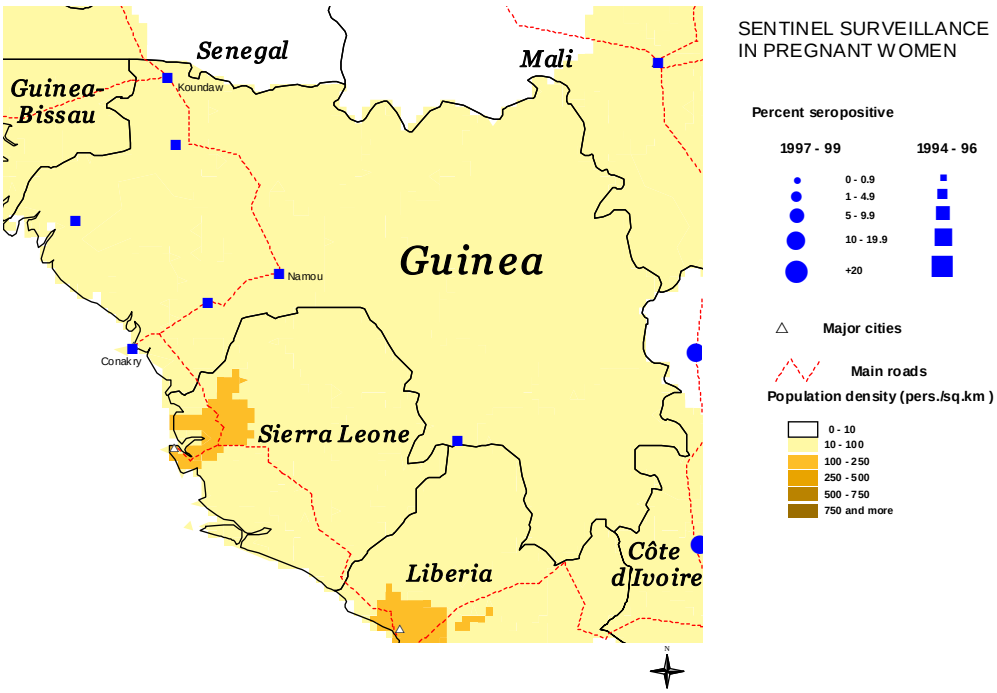
In 1995, 5% of STI clinic patients tested in Conakry were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15–49)	Adult rate (%)	Women (15–49)	Children (0–14)
Source: UNAIDS/WHO, June 2000	55 000	52 000	1.54	29 000	2700

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	30 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	5 600	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1992	15–49	28.0	15.0
Reported non-regular sexual partnership (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1996	1.5	1.5	1.5



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of AIDS in Guinea were found in the literature review. However, a modelling exercise carried out for the World Bank calculated that the annual costs of scaling-up AIDS programmes, to meet the current need, would be about 0.9% of GDP, reflecting a considerable gap in funding to date. The current primary school enrolment is 46%. Although already low compared with other developing countries, AIDS could reduce this even more. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. The potential impact on other sectors, including agriculture, households and firms, has been shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, and must therefore be carefully monitored in future studies of Guinea.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 650 000 primary school students, 1300 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual cost of scaling-up HIV/AIDS programmes nationwide is estimated to be between US$ 25 million and US$ 36 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Politique Nationale de Lutte contre le SIDA, October 1998.

Source: WHO, Guinea

Date: 1 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports	X	
Others: communication	X	

Comments/Key elements:

Source: WHO, Guinea

Date: 1 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
X	

Comments/Key elements: Legal texts on care, non-stigmatization and blood transfusion.

Source: WHO, Guinea

Date: 1 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: "Comité National de lutte contre le Sida et les MST" and the "Comité Technique de lutte contre les MST/SIDA", created in 1998.

Source: WHO, Guinea

Date: 1 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The "Plan National d'Intégration et de Décentralisation des activités de lutte contre le VIH/SIDA/MST," July 1997. Programmatic priorities include prevention, care, youth, non-stigmatization and blood transfusion security.

Source: WHO, Guinea

Date: 1 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

Source: WHO, Guinea

Date: 1 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Financial requirements for the implementation of the national strategic plan are considered in the National Budget for Development (Budget National de Développement).

Source: WHO, Guinea

Date: 1 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	7360	UNPOP
Population aged 15-49 (thousands)	1999	3418	UNPOP
Annual population growth (%)	1990–1998	3.0	UNPOP
% of population urbanized	1998	30	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.0	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1997	550	World Bank
GNP per capita average annual growth rate (%)	1996–1997	1.9	World Bank
Human development index rank (HDI)	2000	162	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	36	UNESCO
Adult male literacy rate	1995	50	UNESCO
Adult female literacy rate	1995	22	UNESCO
Male secondary school enrolment ratio	1996	18.1	UNESCO
Female secondary school enrolment ratio	1996	6.4	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	42	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	1600	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	5.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	121	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	29	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	31	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	56	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper, New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Guinea Bissau

HIV/AIDS epidemiological summary

Information on HIV prevalence among antenatal clinic women has been available from Guinea Bissau since the mid-1980s. In Bissau, the major urban area, HIV-1 prevalence among antenatal clinic women increased gradually from no HIV infection detected in 1987 to 3% in 1995.

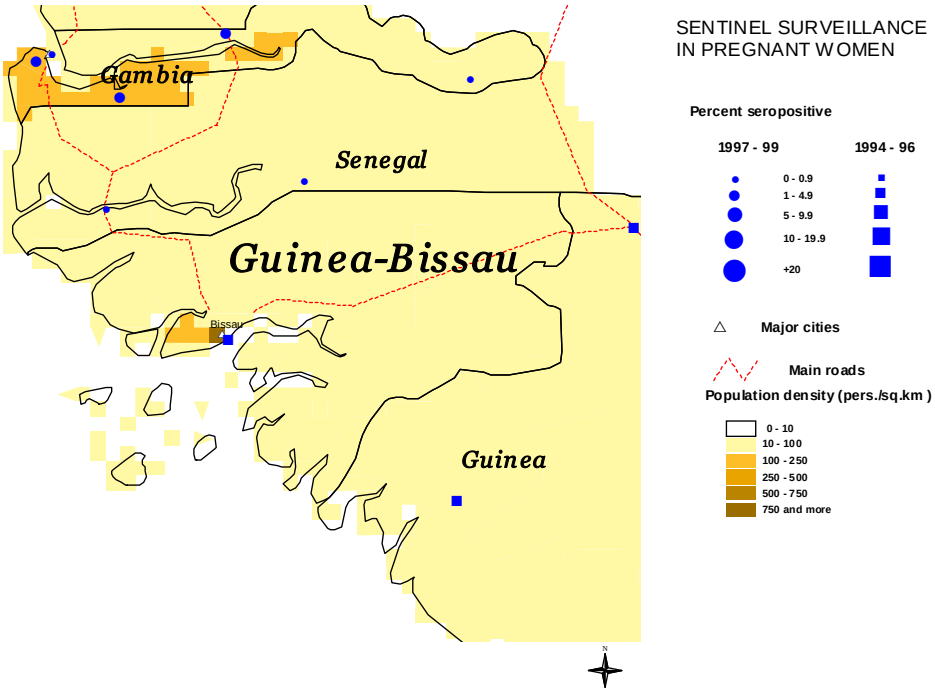
There is no information on HIV prevalence in sex workers or male STI clinic patients.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	14 000	13 000	2.50	7300	560

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	6100	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	1300	UNAIDS/WHO, June 2000

Behavioural Indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1990	15+	50.3	29.5

Measured HIV Prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1995	2.7	2.7	2.7



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of AIDS in Guinea Bissau were found in the literature review carried out. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes, in order to meet the current need, to be between US$ 4 million and US$ 5 million. This represents a per capita cost of around US$ 4 and 0.03% of GDP. The current primary school enrolment is 52.3% and therefore already low compared with other developing countries. AIDS has the potential to push this down further. The potential impact on agriculture and rural areas, shown in other African nations to increase household expenditure, reduce savings and shift productivity patterns, must be carefully monitored, given the high dependency of the economy on the agricultural sector.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Annual costs of scaling-up HIV/AIDS programmes US$ 4 million to US$ 5.5 million (1).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: MTP II was drafted but not finished because of the war.

Source: WHO

Date: 23 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: WHO

Date: 23 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: WHO

Date: 23 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: Effort is being made at presidential level to mobilize all the community around the national response.

Source: WHO

Date: 23 June, 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: MTP II, 1998 – 2002 is used as the framework for national AIDS strategies.

Source: WHO

Date: 23 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Not available

Source: WHO

Date: 23 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: Only an estimation and indicative budget. Needs to be developed for plan implementation.

Source: WHO

Date: 23 June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	1187	UNPOP
Population aged 15–49 (thousands)	1999	531	UNPOP
Annual population growth (%)	1990–1998	2.2	UNPOP
% of population urbanized	1998	22	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.6	UNPOP

Economic indicators	Year	Estimate	Source
GNP per capita (US$)	1997	230	World Bank
GNP per capita average annual growth rate (%)	1996–1997	4.4	World Bank
Human development index rank (HDI)	2000	169	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	55	UNESCO
Adult male literacy rate	1995	68	UNESCO
Adult female literacy rate	1995	43	UNESCO
Male secondary school enrolment ratio	1996	15.1	UNESCO
Female secondary school enrolment ratio	1996	7.2	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	42	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	20	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	910	WHO
Life expectancy at birth	1998	45	UNPOP
Total fertility rate	1998	5.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	128	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	1	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	25	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	63	UNICEF

References

(1) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Kenya

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Kenya since the mid-1980s. In Kenya, the major urban areas are Nairobi and Mombasa. HIV information has been available from Nairobi since 1985 and from Mombasa since 1990. In the major urban areas, HIV prevalence among antenatal women tested increased from 2% in 1985 to 19% in 1995. In 1995, HIV prevalence reached 25% in Nairobi. In 1997, 16% of antenatal clinic attendees in Nairobi tested HIV-positive. HIV prevalence among the same group tested 12% in Mombasa in 1994 and increased slightly in 1997 to 14%. No age breakdown is available. Outside the major urban areas, HIV information became available in 1988 from Machakos and Kajiado in 1989. By 1990, 12 sentinel surveillance sites were reporting HIV information. Among antenatal clinic attendees tested in these sentinel surveillance sites, median HIV prevalence increased from less than 1% in 1988 to 13% in 1997. In 1997, HIV prevalence ranged from 6% to 35% among 15 sentinel surveillance sites. No age breakdown is available.

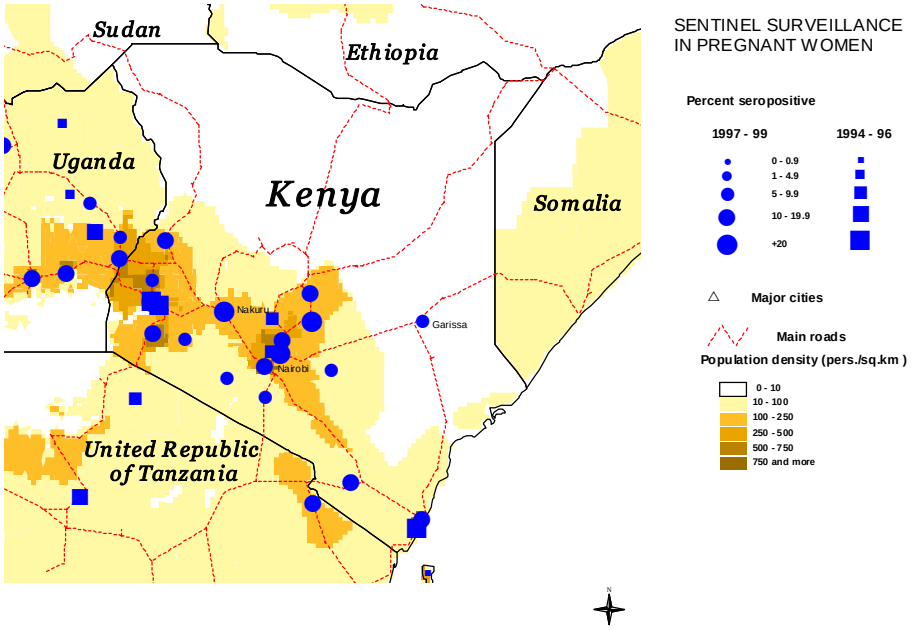
Information on HIV prevalence among sex workers in Nairobi has been available since the mid-1980s. In Nairobi, HIV prevalence among sex workers tested had already reached 62% in 1985 and increased to 86% in 1992. HIV information on sex workers in Mombasa was only available for 1989 and 1993–95. In 1993–95, 55% of sex workers tested in Mombasa were HIV-positive. Information on HIV prevalence among male STI clinic patients has been available from Nairobi since 1985. HIV prevalence among male STI clinic patients tested in Nairobi increased from 16% in 1985 to 28% in 1991-92. In 1996, 14% of STI clinic patients tested in Nairobi were HIV-positive. HIV information on male STI clinic patients from Mombasa is only available for 1994: 9% tested HIV-positive. Among female STI clinic patients tested in Nairobi, HIV prevalence increased from 14% in 1989 to 29% in 1998.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	2 100 000	2 000 000	13.95	1 100 000	78 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	730 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	180 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with non-regular partner (%)	1998	15-49	42.5	15.1
Reported non-regular sexual partnership over a 12-month period (%)	1998	15-49	19	5

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	15.2	14.4	15.9



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS on Kenya are relatively extensive, compared with many other countries in sub-Saharan Africa. In particular, a study carried out by AIDSCAP/Family Health International has provided extensive data to help with planning and policy decisions in each of the sectors. Of the sectors explored here, the studies in health demonstrate that the health system is being stretched by the need to care for people with AIDS, and there is still a large gap in funding for a scaled-up care and prevention programme, equivalent to 1.2% of GDP. Studies in the area of business and agriculture are still limited but show costs in terms of reduced labour time and increased medical and burial costs. Finally, there is little work in the area of education and more detailed studies are required to understand the full impact on this sector, in order to shape responses appropriately.

Macroeconomic impact

An early model of the economic impact of AIDS in Kenya predicted a reduction in GDP of 14.5% by 2005 (1). Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 1.3% by 2010 (2).

Economic impact of HIV/AIDS on households

Households are estimated to lose 49%–78% of their income when one person dies from AIDS (excluding funeral costs) (3).

Economic impact of HIV/AIDS on agriculture

On an agro-estate in Nyanza Province, costs due to AIDS-related funerals between 1992/93 and 1998/99 tripled (4).

Economic impact of HIV/AIDS on firms

Supply: In a study of six firms in 1994, the AIDS-related loss in profit varied between 0% and 6% (1.7% on average). The projected increase in AIDS-related profit loss for 2005, in those same firms, was calculated to be 0-14% (4% on average) (5). In a separate survey of four firms, the annual cost per employee with AIDS was found to be between US$ 17 and US$ 49 (6), (7) and (8) cited in (9).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 5.6 million primary school students, 95 000 would have lost a teacher to AIDS in 1999 (10).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Bed occupancy rates for HIV/AIDS-related diseases is 30% in major central hospitals and between 10% and 30% in district hospitals (11).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 78 million and US$ 125 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Sessional Paper no 4 of 1997 on AIDS in Kenya, Ministry of Health/Republic of Kenya

Source: The National AIDS Control Council

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: Efforts are under way to establish mainstream HIV/AIDS programmes, where necessary, and to retrofit HIV/AIDS programmes in the concerned ministries.

Source: The National AIDS Control Council

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Kenya

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

The National AIDS Control Council

Following the Presidential address in December 1999, declaring AIDS a disaster, a National AIDS Council was created by Presidential decree. The National AIDS Council is located at the office of the President and consists of Permanent Secretaries, NGOs, associations of people living with HIV/AIDS and representatives of private sectors. The Chairman of the National AIDS Council is Dr Abdalla Mohamed. The Chairman of the National AIDS Council reports to the Minister in charge of Presidency and Internal Security, Mr Madoka Masden.

The Kenya HIV/AIDS Consultative Group

This is a forum that includes heads of UN agencies, bilateral donors, the Government of Kenya, People Living with HIV/AIDS, representatives of private sectors, NGOs and religious organizations. The objectives of the Kenya HIV/AIDS Consultative Group are defined as follows: priority-setting, advocacy and promotion of multisectoral approaches, information sharing, and promotion of regional and international initiatives and actions recommended by the Technical Working Group. The Government of Kenya, with the UNTG as the secretariat, chairs the HIV/AIDS consultative group.

Source: UNAIDS Kenya

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The strategic planning process, which started in 1998, was completed in 1999 when the Strategic Plan for the Kenya National HIV/AIDS & STD Control Programme, 1999–2004, was completed. The plan is being reviewed and re-costed.

Source: Strategic Plan for the Kenya National HIV/AIDS & STD Control Programme, 1999–2004

Date: June 1999

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Seven key initiatives are presented in the national strategic plan as priority components:

Advocacy and promotion of behaviour change

Blood safety

Continuum of care and support

Treatment and control of sexually transmitted diseases

Epidemiology and research

Prevention of mother-to-child transmission of HIV

Mitigation of the socioeconomic Impact

Source: Strategic Plan for the Kenya National HIV/AIDS & STD Control Programme, 1999–2004

Date: June 1999

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: There is a budget (US$ 33 million) for the implementation of the Strategic Plan. However, this budget is currently being reviewed and re-costed. Current estimate is US$ 187 million over the period 1999–2004.

Source: The National AIDS Control Council/UNAIDS Kenya

Date: July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	29 549	UNPOP
Population aged 15-49 (thousands)	1999	14 261	UNPOP
Annual population growth (%)	1990–1998	2.6	UNPOP
% of population urbanized	1998	30	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.4	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	340	World Bank
GNP per capita average annual growth rate (%)	1996–1997	0.4	World Bank
Human development index rank (HDI)	2000	138	UNDP
% population economically active	-	43.3	ILO
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	78	UNESCO
Adult male literacy rate	1995	86	UNESCO
Adult female literacy rate	1995	70	UNESCO
Male secondary school enrolment ratio	1996	25.7	UNESCO
Female secondary school enrolment ratio	1996	21.8	UNESCO

Health indicators	Year	Estimate	Source
Crude birth rate (births per 1000 pop.)	1999	34	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	650	WHO
Life expectancy at birth	1998	52	UNPOP
Total fertility rate	1998	4.4	UNPOP
Infant mortality rate (per 1000 live births)	1999	65	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	34	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	44	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	76	UNICEF

References

(1) Hancock, J. et al. The macroeconomic impact of HIV/AIDS. In: Forsythe, S., Rau B., editors, *AIDS in Kenya*. Arlington, Virginia, USA: Family Health International (FHI), 1996.

(2) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(3) Leighton, C. The direct and indirect costs of HIV/AIDS. In: Forsythe, S., Rau, B., editors, *AIDS in Kenya*. Arlington, Virginia, USA: Family Health International (FHI), 1996.

(4) Rugalema, G., Weigang, S., and Mbwika, J. HIV/AIDS and the Commercial Agricultural Sector of Kenya*. Impact, Vulnerability, Susceptibility and Coping Strategies*. UNDP and FAO, 1999.

(5) Roberts, M., Wang'ombe J., Forsythe, S. Business response to HIV/AIDS in the African Formal Sector Workplace: Findings of a Kenyan Needs Assessment. In: Forsythe, S., Rau, B., editors, *AIDS in Kenya*. Arlington, Virginia, USA. Family Health International (FHI), 1996.

(6) Roberts, M. and Rau, B. *Private Sector AIDS Policy African Workplace Profiles: Case Studies on Business Managing HIV/AIDS*. The AIDSCAP Electronic Library, 1997.

(7) Aventin, L., Huard, P. HIV/AIDS and manufacturing in Abidjan. *AIDS Analysis Africa* 1997; 7(3).

(8) Ainsworth, M. *The Impact of HIV/AIDS on African Development*. 1993. Presented at the African Development Bank HIV/AIDS and Development in Africa Symposium Mali 1993.

(9) Stover, J. and Bollinger, L. *The Economic Impact of AIDS*. The Policy Project: Futures Group International/ Research Triangle Institute/ Centre for Development and Population Activities, 1999.

(10) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(11) Ngugi, E. *A Desk Review of Medium Term Plan II*. Kenya, Ministry of Health, 1995.

Lesotho

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from sentinel surveillance studies as of 1991. The sentinel surveillance sites selected are from the lowlands and do not include women from the mountain areas. In Maseru, the major urban area, 6% of antenatal clinic women tested HIV-positive in 1991 and 1993. However, in 1994, HIV prevalence among antenatal clinic attendees rose dramatically to 31%. There are no recent data from Maseru. HIV prevalence among women tested in Leribe, Maluti, Mafeteng and Quthing increased from 2% in 1991 to 27% in 1999.

There is no information available on HIV prevalence among sex workers.

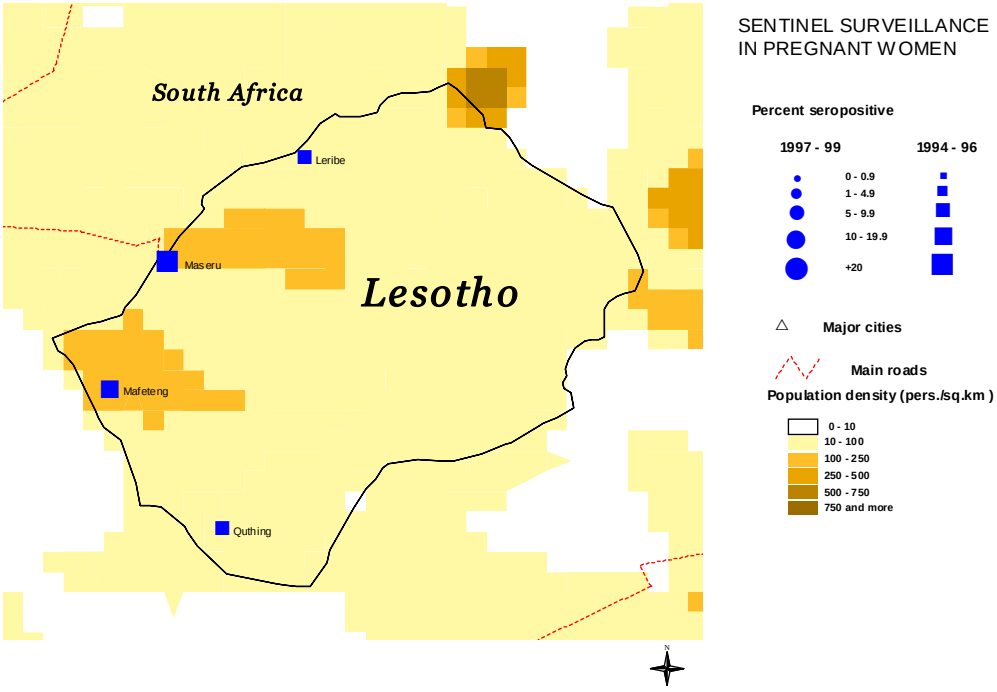
HIV sentinel surveillance information has been available for STI clinic patients since the late 1980s. In Maseru, HIV prevalence among STI clinic patients tested increased from 1% in 1989 to 11% in 1993. There is no recent information from Maseru. Outside Maseru, HIV prevalence among male STI clinic patients increased from 5% in 1991 to 41% in 1999.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	240 000	240 000	23.57	130 000	8200

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	35 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	16 000	UNAIDS/WHO June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1989	15+	52.6	28.4

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1994	31.4	31.4	31.4



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of AIDS in Lesotho were found in the literature review carried out. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 10 million and US$ 15 million or approximately 1.5% of GDP. In the area of education, a UNAIDS/UNICEF model shows that increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. The current primary school enrolment is nearly 70%. This discontinuity, along with increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in this area, reducing enrolment and, hence, literacy rates. Likewise, the potential impact on other sectors, including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, need to be carefully monitored in future studies.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 360 000 primary school students, 6200 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes nationwide is estimated to be between US$ 10.5 million and US$ 14.9 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Draft ready and due for adoption, together with the Strategic Plan, at the end of June 2000.

Source: UNAIDS Lesotho

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace	X	
Sports		X
Others		X

Comments/Key elements: Ministry of Labour has adopted the SADC Code of Conduct

Source: UNAIDS Lesotho

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Lesotho

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: 1) Structures that have been put in place to address the epidemic include National AIDS Committee, LAPCA, Districts, Sectoral Taskforces. 2) The National AIDS Committee advises the government on HIV/AIDS/STI policy, advocates for political commitment and provides guidance for the implementation of the National Strategic Plan. 3) LAPCA plays the role of Secretariat, initiating and harmonizing HIV/AIDS/STI activities for an effective national multisectoral response. It also coordinates research activities, advises on resource allocation, provides information and technical advice and facilitates inter-sectoral collaboration. 4) Districts play a central role at the local level. They formulate sectoral plans and cost them for implementation, mobilize resources, monitor and evaluate activities and establish operational and management mechanisms while ensuring that Sectoral Technical AIDS Committees are functional. (5) Taskforces formulate sectoral action plans and cost them for implementation. They mobilize and allocate resources, identify key actors and collaborators, defining their roles, and prepare and submit quarterly reports to LAPCA.

Source: UNAIDS Lesotho

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: A National AIDS Strategic Plan has been developed to cover the period 2000–2003. The Plan will be presented to the Cabinet and nation in June 2000.

Source: UNAIDS

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Not available

Source: UNAIDS

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Not available

Source: UNAIDS Lesotho

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	2108	UNPOP
Population aged 15-49 (thousands)	1999	1000	UNPOP
Annual population growth (%)	1990–1998	2.3	UNPOP
% of population urbanized	1998	25	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.1	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	680	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.1	World Bank
Human Development Index rank (HDI)	2000	127	UNDP
% population economic active	-	43.3	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	71	UNESCO
Adult male literacy rate	1995	81	UNESCO
Adult female literacy rate	1995	62	UNESCO
Male secondary school enrolment ratio	1996	23.3	UNESCO
Female secondary school enrolment ratio	1996	34.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	35	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	610	WHO
Life expectancy at birth	1998	56	UNPOP
Total fertility rate	1998	4.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	92	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	23	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	50	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	50	UNICEF

References

(1) UNICEF. *The Progress of Nations, 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Liberia

HIV/AIDS epidemiological summary

Scant information on HIV prevalence is available for Liberia. In Monrovia, 4% of antenatal clinic women tested positive for HIV in 1992 and 1993. In 1996 and 1997, HIV testing at various sites found no evidence of HIV infection among antenatal clinic attendees. In 1998, however, at an unspecified site, 10% of antenatal clinic attendees were found to be HIV–positive.

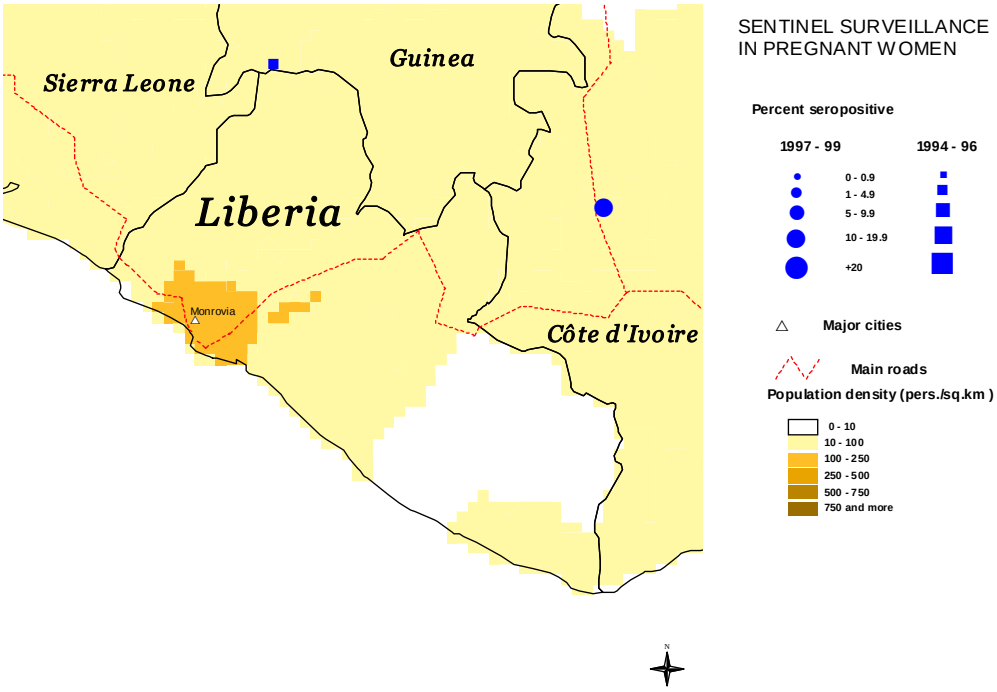
There is no information available on HIV prevalence among sex workers. In 1993, 8% of male STI clinic patients attending one site in Monrovia tested positive for HIV.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	39 000	37 000	2.8	21 000	2000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	31 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	4500	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1993	4.0	4.0	4.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Liberia were found. However, if the epidemic develops at the same pace here as it has in many African nations, the impact will be felt in most sectors. In households and in the agricultural sector, illness and death may lead to increased expenditures, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: The National HIV/AIDS policy document is being finalized. It is expected for December 2000.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: In collaboration with the NACP, a technical committee has drafted a paper on ethical issues in the national response. The document is not yet finalized.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: The National AIDS Commission reporting to the Ministry of Health.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: The national strategic plan is being developed. The situation and response analyses have been done. A consensus workshop is planned for August 2000. Effort is being made to create multisectoral involvement, including bilaterals and NGOs, in the design and implementation of a national response.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Identified priorities are: blood safety, information, education and communication, surveillance, voluntary counselling and testing, care for the sick.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: The budget will be prepared following the costing of the strategic plan.

Source: HIV/AIDS focal point, WHO, Liberia

Date: 21 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	2930	UNPOP
Population aged 15–49 (thousands)	1999	1378	UNPOP
Annual population growth (%)	1990–1998	0.4	UNPOP
% of population urbanized	1998	44	UNPOP
Average annual growth rate of urban population (%)	1990–1998	1.0	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	-	-	-
GNP per capita average annual growth rate (%)	-	-	-
Human Development Index rank (HDI)	-	-	-
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	38	UNESCO
Adult male literacy rate	1995	54	UNESCO
Adult female literacy rate	1995	22	UNESCO
Male secondary school enrolment ratio	1996	20.4	UNESCO
Female secondary school enrolment ratio	1996	8.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	44	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	14	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	560	WHO
Life expectancy at birth	1998	48	UNPOP
Total fertility rate	1998	6.3	UNPOP
Infant mortality rate (per 1000 live births)	1999	96	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	6	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	58	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	19	UNICEF

References

Libyan Arab Jamahiriya

HIV/AIDS epidemiological summary

Very little information is available on the current status of HIV prevalence in the Libyan Arab Jamahiriya.

In 1990, 18% of sex workers tested in one site were HIV-positive. However, in 1993 and 1994, only 1% of sex workers tested were HIV-positive.

Among IV drug users tested in 1998, 0.5% were HIV-positive.

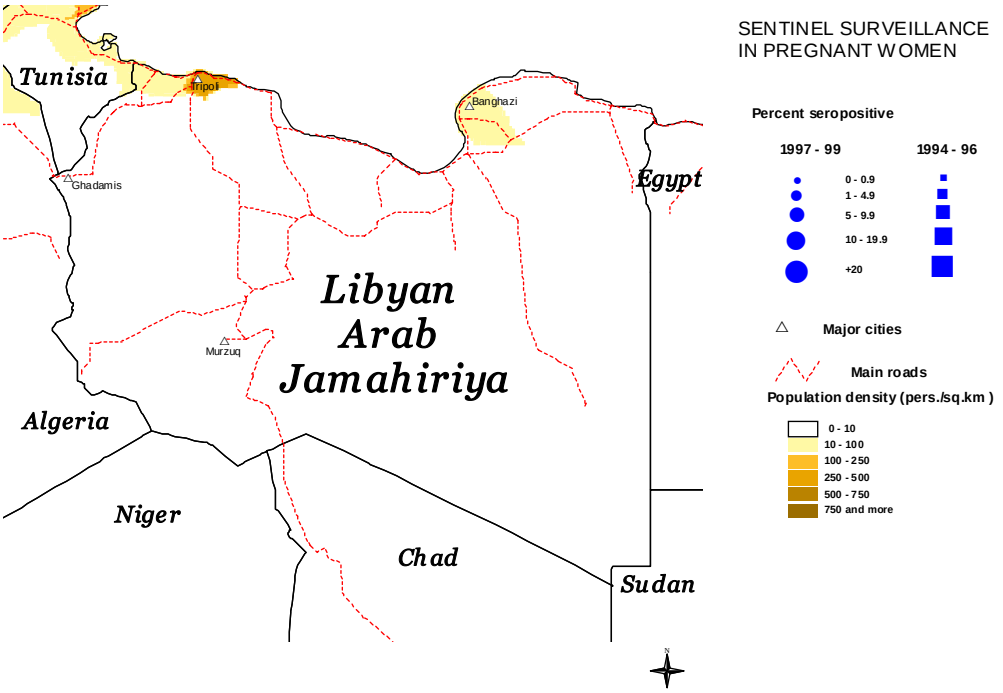
There was no evidence of HIV infection among antenatal clinic attendees tested in 1998, nor among STI clinic patients and army recruits tested in 1990.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	1400	0.05	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV Prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Libyan Arab Jamahiriya were found. However, if the epidemic develops at the same pace here as it has in many African nations, the impact will be felt in most sectors. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required in order for us to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required for an understanding of how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

Not available

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	5471	UNPOP
Population aged 15–49 (thousands)	1999	2770	UNPOP
Annual population growth (%)	1990–1998	2.4	UNPOP
% of population urbanized	1998	84	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.7	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	-	-	-
GNP per capita average annual growth rate (%)	-	-	-
Human Development Index rank (HDI)	2000	72	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	-	-	-
Adult male literacy rate	1995	86	UNESCO
Adult female literacy rate	1995	63	UNESCO
Male secondary school enrolment ratio	1996	102.9	UNESCO
Female secondary school enrolment ratio	1996	96.4	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	29	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	5	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	220	WHO
Life expectancy at birth	1998	70	UNPOP
Total fertility rate	1998	3.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	27	UNPOP/UNICEF
Contraceptive prevalence rate (%)	1990–1999	45	UNPOP/UNICEF
% of births attended by trained health personnel	1990–1999	94	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	97	UNICEF

References

Madagascar

HIV/AIDS epidemiological summary

Recent information from Madagascar indicates that HIV prevalence is still very low in the country. Sentinel surveillance data have been available from Antananarivo, the major urban area, since 1990 and through 1996. No evidence of HIV infection among antenatal clinic women has been found. Outside Antananarivo, HIV sentinel surveillance among antenatal clinic women has been conducted since 1990. Out of 15 sentinel surveillance sites, only one site, Toamasina, found evidence of HIV infection among antenatal clinic attendees in 1995; 0.2% of women tested were HIV-positive. In 1996, three-out-of-ten sites reporting found evidence of HIV infection. In Toamasina, 1% of antenatal clinic women tested positive. In Antsiranana and Maroantsetra, less than 1% of antenatal clinic attendees tested were HIV-positive.

HIV prevalence among sex workers in Antananarivo increased from 0.3% of women tested in 1995 to 1% in 1998. In 1995 and 1996, outside Antananarivo, evidence of HIV prevalence among sex workers was found in only two sites. In Antsiranana, 1-2% of sex workers tested HIV-positive. In Toamasina, less than 1% of sex workers tested were HIV-positive in 1995.

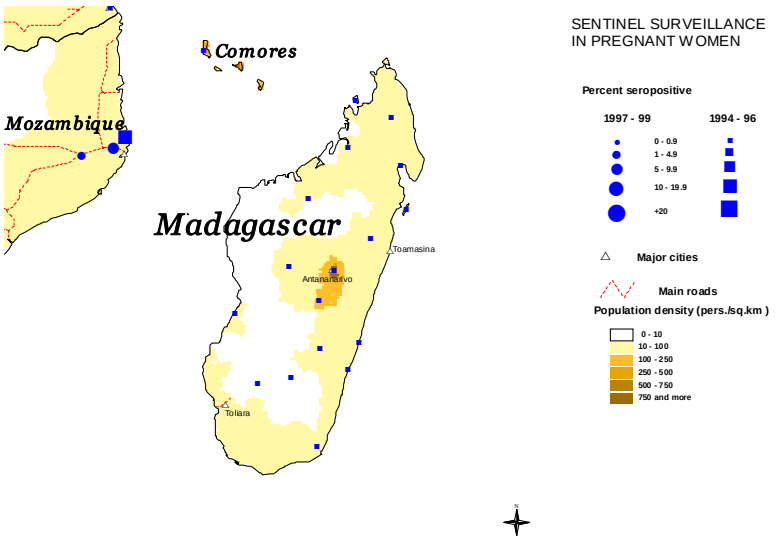
In Antananarivo, less than 1% of STI clinic patients tested HIV-positive in 1995 and no evidence of HIV infection was found in 1996. In 1998, 2% of STD clinic patients in one clinic in Antananarivo tested HIV-positive. Outside of Antananarivo, 14 sentinel surveillance sites reported in 1995. HIV prevalence ranged from no evidence of infection to 7% in Antsiranana. Nine of the 14 sites found no evidence of HIV infection among STI clinic patients. In 1996, however, HIV prevalence ranged from no evidence of infection to only 0.7% from 12 reporting sites. In 1996, less than 0.5% of STI clinic patients in Antsiranana tested HIV-positive. In 1998, HIV prevalence information was only available from two clinics, where no evidence of HIV infection was found.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	11 000	10 000	0.15	5800	450

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	2600	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	870	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1996	0.0	0.0	0.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of AIDS in Madagascar were found in the literature review carried out. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 35 million and US$ 53 million, or approximately 1.5% of GDP. In the area of education, a UNAIDS/UNICEF model shows how increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. The current primary school enrolment is nearly 59%. This discontinuity, along with increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in this area, reducing enrolment and, hence, literacy rates. The potential impact on other sectors including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, need to be carefully monitored in future studies to ensure an appropriate policy response.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 2 million primary school students, 273 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimate to be between US$ 35 million and US$ 53 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Current NSP covers 1996–2000

Source: CPA report

Date: December 1999

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education	X	
Health	X	
Military	X	
Workplace		
Sports	X	
Others: justice, population	X	

Comments/Key elements: MTP II.

Source: CPA report

Date: December 1999

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements: Unknown

Source: UNAIDS

Date: July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: CNLS chaired by the MOH includes 11 Ministers

Source: CPA report

Date: December 1999

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: MTP II (1996-2000)

Source: CPA report

Date: December 1999

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: UNAIDS

Date: July 2000

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: UNAIDS

Date: July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	15 497	UNPOP
Population aged 15–49 (thousands)	1999	7197	UNPOP
Annual population growth (%)	1990–1998	3.2	UNPOP
% of population urbanized	1998	27	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.2	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	250	World Bank
GNP per capita average annual growth rate (%)	1996–1997	1.5	World Bank
Human Development Index rank (HDI)	2000	141	UNDP
% population economically active	-	43.8	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	81	UNESCO
Adult male literacy rate	1995	88	UNESCO
Adult female literacy rate	1995	73	UNESCO
Male secondary school enrolment ratio	1996	12.8	UNESCO
Female secondary school enrolment ratio	1996	12.7	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	39	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	10	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	490	WHO
Life expectancy at birth	1998	58	UNPOP
Total fertility rate	1998	5.4	UNPOP
Infant mortality rate (per 1000 live births)	1999	80	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	19	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	47	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	68	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Malawi

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s from Malawi. In Malawi, Lilongwe, Blantyre and Mzuzu are considered major urban areas. From 1985 to 1993, HIV prevalence among antenatal women increased from 2% to 30%. In 1998, 26% of antenatal clinic attendees tested HIV-positive. In 1997, 17% of the women less than 20 years of age were HIV-positive. Peak HIV prevalence of 32% was seen among women aged 25–29 years of age.

Outside of major urban areas, HIV prevalence among antenatal women tested increased from 6% in 1992 to 18% in 1998. The range of HIV prevalence among antenatal women tested in 14 sites[1] in 1998 was from 6% to 25%. In 1998, combined age data were available from all 19 sites, including the major sites and outside of the major urban areas. Fourteen per cent of the women less than 20 years of age were HIV-positive and peak prevalence of 28% was reported among women 25–29 years of age.

In 1986, 56% of sex workers tested in Blantyre were HIV-positive. In 1994, 70% of sex workers tested in Lilongwe were HIV-positive.

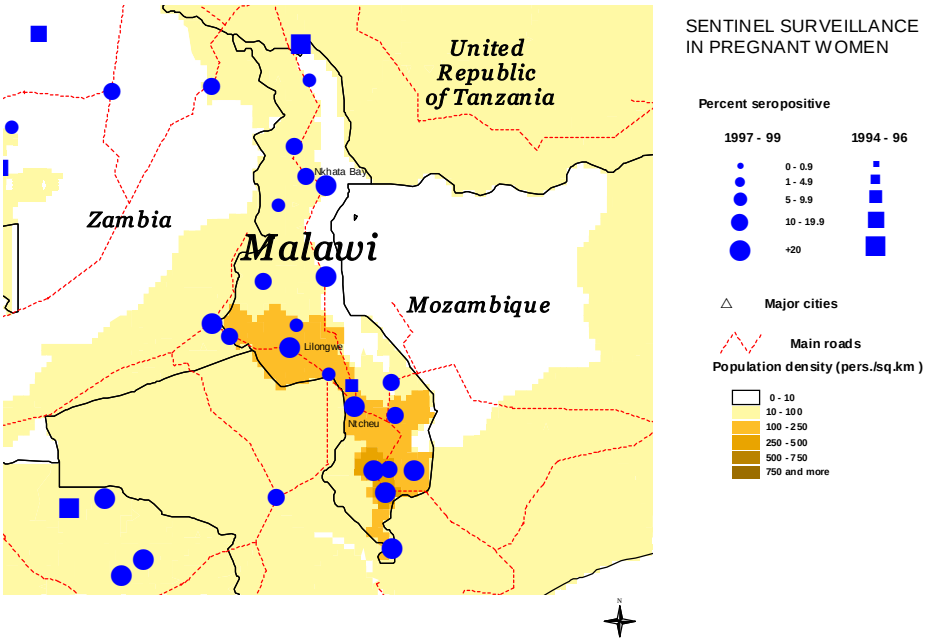
Over 50% of STD clinic patients tested in the major urban areas between 1989 and 1996 were HIV-positive. In 1995, 46% of STI clinic patients tested at seven sites outside of the major urban areas were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	800 000	760 000	15.96	420 000	40,000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	390 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	70 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	26.0	18.5	30.4



1 Two of the reporting sites had sample sizes of less than 100.

Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Malawi are extensive when compared with other countries of sub-Saharan Africa. Studies available include the macroeconomic impact, assessment and planning work carried out by the World Bank and the Government of Malawi, and a study on a commercial tea estate. Much of this work uses regional data to model potential impact on the economy or economic sectors. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is average for sub-Saharan Africa. Of the sectors explored, no data are available on the impact of AIDS at the household level. The studies in business show a reduction in profits due to AIDS-related morbidity and mortality. In education, increasing mortality rates due to AIDS have led to discontinuity in teaching, with many pupils losing or having a change in their teachers. The health sector studies demonstrate that there is a large gap in funding to meet the full needs of a scaled-up care and prevention programme, equivalent to US$ 3-4 per capita and 1.9% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 0.7% by 2010 (1).

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

On a Makandi tea and coffee estate, production loss as a result of AIDS was shown to be 3.4% of gross profit in 1995/96 (2).

Economic impact of HIV/AIDS on firms

Supply: AIDS-related costs were found to be 1.1% of total costs and 3.4% of gross profits in Lonrho companies in 1992 (3).

Economic impact of HIV/AIDS on education

Supply: a model developed by UNAIDS and UNICEF in 2000 shows that, of around 2.8 million primary school students, 52 000 would have lost a teacher to AIDS in 1999 (4). By 1997, over 10% of education personnel in urban areas are estimated to have died from AIDS and, by 2005, this figure is projected to increase to 40% (5). In one district, 10% of teachers died in the first term of the 1998/9 academic year (6). Malawi Schools Support Systems Programme Review Report projects cumulative AIDS deaths among primary school teachers and secondary school teachers to be 2369 and 284, respectively, by 2001, and 6158 and 739 by 2006, cited in (7).

Demand: Not available

Economic impact on the health sector

Supply: It is estimated that, by 1997, over 10% of health, education and military personnel in urban areas would have died from AIDS; by 2005, this figure is projected to increase to about 40% (5).

Demand: AIDS patient numbers were estimated to have at least equalled the total number of all other causes of outpatient visits in 1996 (5). Approximately 20% of MOH curative budget is spent on HIV/AIDS-related expenditure (5).

Resource gap: The annual cost of scaling-up HIV/AIDS activities is estimated to be between US$ 31million and US$ 48 million (8).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: Will include: MTCT, multisectoral issues, gender, VCT, human resource management, other legal and ethical issues. Currently being developed. Estimated completion by October 2000.

Source: UNAIDS Malawi

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military	X in draft	
Workplace		X
Sports		X
Others (prisons & immigration)	X In draft	

Comments/Key elements: Processes are under way in agriculture, education, sports and other sectors to incorporate HIV/AIDS into their sectoral policies.

Source: UNAIDS Malawi

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Malawi

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
x	

Comments/Key elements: A cabinet committee on HIV/AIDS prevention and care, chaired by the Vice President, was established in 1998 to oversee the activities of the National AIDS Control Programme and to provide support to issues requiring urgent attention. Within the context of the National Strategic Planning Framework, the placement, legal status, and staffing of the National AIDS Secretariat is being reviewed to identify the changes required to enable the Secretariat to effectively manage and coordinate an expanded multisectoral response. An inter-ministerial committee is being established to coordinate public sector interventions and to monitor the extent and quality of mainstreaming of HIV/AIDS into the different sectors.

Source: UNAIDS Malawi

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
x	

Comments/Key elements: The National HIV/AIDS Strategic Framework (2000-2004) and the Agenda for Action, which were launched on 29 October 1999, are the culmination of a national process that started in February 1998. The framework sets out goals, guiding principles, broad objectives and strategies for the country for the period 2000–2004. The activities of the framework have been costed and the financial resource gap has been estimated in broad terms. The National AIDS Secretariat has done prioritization in terms of the interventions requiring urgent attention to stem the epidemic and to provide for a strengthened NACP, necessary to manage and coordinate the national response. A Round Table to mobilize resources for the implementation of the Framework was conducted in March 2000.

Following the launch of the National HIV/AIDS Strategic Framework, a process was initiated to develop district-specific plans. While the district plans will be based on the national framework, the contents of each plan will vary, depending on the circumstances and priorities in that district. District Assemblies will be responsible for implementation, monitoring and evaluation of their activities. Six district plans were in place by the end of March and the remaining 20 districts are expected to have plans in place by the last quarter of 2000.

Source: NACP/ Malawi

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
x	

Comments/Key elements:

The priorities are as follows:

1) Dissemination of the National Strategic Framework for HIV/AIDS through the development of district-specific implementation plans.
2) Institutional capacity building: NACP—staffing, equipment/materials funding and monitoring and evaluation; NGOs/CBOs—strengthening coordination mechanisms in place.
3) Prevention: Interventions for youth (behavioural change, youth-friendly reproductive health services, life skills programmes), STI management, condom promotion, prevention of MTCT, blood safety, exploration of modalities for increasing access to antiretroviral drugs and treatment of opportunistic infections.

Source: NACP/ Malawi

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
x	

Comments/Key elements: The total cost estimated for implementing the framework (activities and institutional support) over the period 2000-2004 is US$ 121 million. Government contribution is US$ 445 000. It should be noted that the estimated government contribution does not include financial resources consumed by HIV/AIDS patients in health care facilities. About 70% of inpatients in public health care facilities are suffering from HIV/AIDS-related illnesses, which implies that most of the recurrent expenditure in the public health care facilities is spent on HIV/AIDS-related illnesses. All of the foregoing, of course, means that the government contribution noted above is grossly inadequate. The resource mobilization round table, organized in March 2000 to mobilize funds for the implementation of the framework, raised in excess of US$ 100 million.

Source: UNAIDS Malawi

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	10 640	UNPOP
Population aged 15-49 (thousands)	1999	4694	UNPOP
Annual population growth (%)	1990-1998	1.3	UNPOP
% of population urbanized	1998	14	UNPOP
Average annual growth rate of urban population (%)	1990-1998	2.9	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	210	World Bank
GNP per capita average annual growth rate (%)	1996-1997	2.5	World Bank
Human Development Index rank (HDI)	2000	163	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	56	UNESCO
Adult male literacy rate	1995	72	UNESCO
Adult female literacy rate	1995	42	UNESCO
Male secondary school enrolment ratio	1996	22.0	UNESCO
Female secondary school enrolment ratio	1996	12.2	UNESCO

Health indicators	Year	Estimate	Source
Crude birth rate (births per 1000 pop.)	1999	47	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	23	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	560	WHO
Life expectancy at birth	1998	39	UNPOP
Total fertility rate	1998	6.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	135	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	19	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	47	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	68	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Jones C. What HIV costs a tea estate in Malawi. *AIDS Analysis Africa* 1997; 7(3):5-7.

(3) Ntirunda and Zimba. *The Impact of HIV/AIDS on production: the experience with Lonrho companies, Malawi.* Paper represented at the International Conference on AIDS, Geneva, 1998.

(4) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(5) The World Bank. *Malawi AIDS Assessment Study*. 10. Washington D.C., World Bank, 1998.

(6) Government of Malawi and UNICEF. *Youth and Education Sectoral Review*. Malawi, Government of Malawi/UNICEF, 1999.

(7) Tayari, M. *Assessment of the Impact of HIV/AIDS on the supply and demand of primary education in Malawi*. Draft. Department for International Development (UK) - Education Sector, 2000.

(8) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Mali

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Mali since the late 1980s. In Bamako, the major urban area, HIV prevalence increased among antenatal clinic attendees tested from 1% in 1987 to 4% in 1994 and 3% in 1997. However, these rates include HIV-2; information by virus type was not available. Outside Bamako, HIV prevalence information is available from Kayes, Koulikoro, Sikasso, Segou, Mopti, Tombouctou and Gao. HIV prevalence ranged from no evidence of infection to 9% in 1987, from no evidence of infection to 3% in 1987-89 and from 3% to 5% in 1994. Once again, these rates include HIV-2; information by virus type was not available.

Information on HIV prevalence among sex workers has been available since the late 1980s. In Bamako, 39% of workers in 1987 tested HIV-positive. HIV prevalence among this group reached 74% in 1992. In 1995, 56% of sex workers tested in Bamako were HIV-positive. Outside Bamako, information on HIV prevalence among sex workers is available from Kayes, Koulikoro, Sikasso, Segou, Mopti, Tombouctou and Gao. HIV prevalence ranged from no evidence of HIV infection to 40% of sex workers tested in 1987. In 1992, HIV prevalence ranged from 16% to 74% of sex workers tested in five sites. HIV prevalence rates for 1995 are only available from Mopti and Sikasso, where 21% and 72%, respectively, of sex workers tested HIV-positive. These rates include HIV-2.

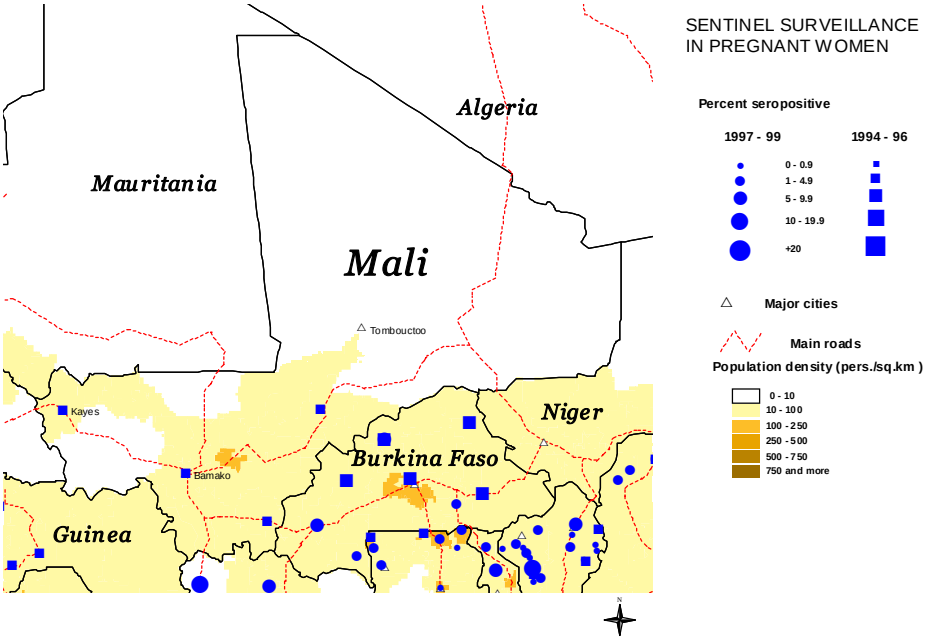
There is no information available on HIV prevalence among male STI clinic patients.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	100 000	97 000	2.03	53 000	5000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	45 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	9900	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	2.7	2.7	2.7



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Mali are limited. International studies using models to explore the effect of AIDS on the education and health systems provide information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. Evidence shows the large expenditure on health care at the household level that may have an impact on savings. No data were found for the impact in the agricultural sector or for businesses, but it can be assumed that firms will have increasing costs as a result of AIDS-related medical and funeral expenses. In the public sectors, an education model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Further data are also required to understand how the epidemic is impacting on demand for education and health, as well as how supply in the health sector might be affected by rising infection rates in health care workers. There are still extensive investments required to scale-up AIDS programmes: equivalent to US$ 2 per capita and 1.2% of GDP.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Patient expenditures during hospitalization as a result of AIDS ranged from 100 000 FCFA to 150 000 FCFA in 1990 (1).

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 780 000 primary school students, 2000 would have lost a teacher to AIDS in 1999 (2).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 20 million and US$ 30 million (3).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	NA

Comments/Key elements: Not available

Source: CPA

Date: 22 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: CPA

Date: 22 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: National AIDS Committee

Source: CPA

Date: 22 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: Under development

Source: CPA

Date: 22 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	10 960	UNPOP
Population aged 15–49 (thousands)	1999	4773	UNPOP
Annual population growth (%)	1990–1998	2.4	UNPOP
% of population urbanized	1998	28	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.2	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	260	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.5	World Bank
Human Development Index rank (HDI)	2000	165	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	31	UNESCO
Adult male literacy rate	1995	39	UNESCO
Adult female literacy rate	1995	23	UNESCO
Male secondary school enrolment ratio	1996	14.4	UNESCO
Female secondary school enrolment ratio	1996	7.3	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	46	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1200	WHO
Life expectancy at birth	1998	54	UNPOP
Total fertility rate	1998	6.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	116	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	7	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	24	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	52	UNICEF

References

(1) Tall CT. *Le coût et la prise en charge du SIDA en milieu hospitalier au Mali*. Bamako, 1990.

(2) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(3) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Network Symposium, Durban, South Africa, 7-8 July 2000.

Mauritania

HIV/AIDS epidemiological summary

There was no evidence of HIV infection among antenatal clinic women in Nouakchott, the major urban area, in 1987–88. In 1993–94, 0.5% of antenatal clinic women tested in Nouakchott were HIV-positive.

Also in 1993–94, 1% of male STI clinic patients tested in Nouakchott were HIV-positive.

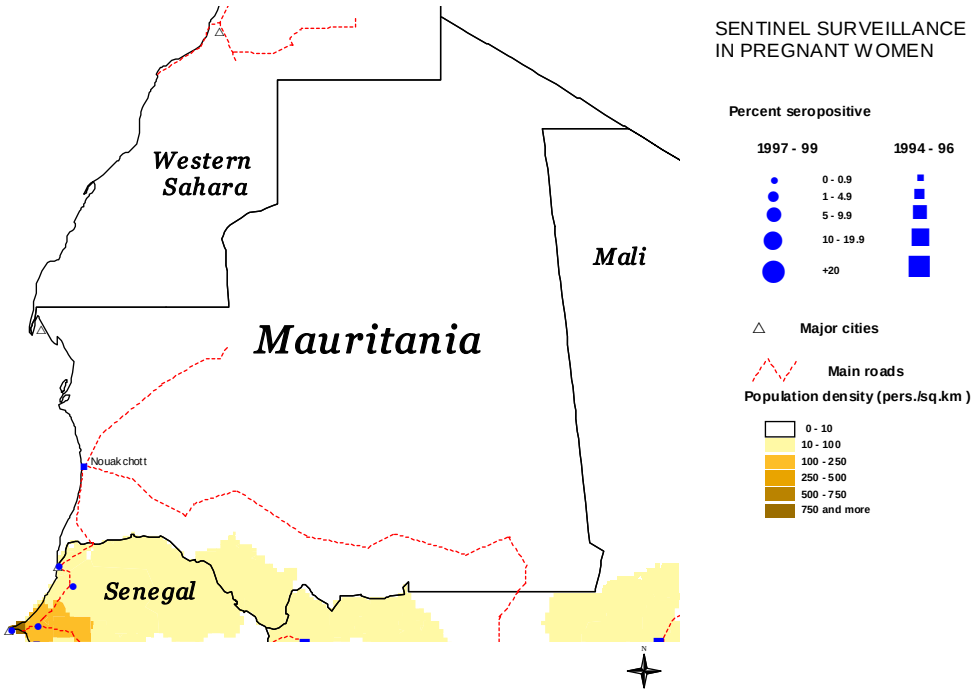
There is no information on HIV prevalence in sex workers.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	6600	6300	0.52	3500	260

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	610	UNAIDS/WHO, June 2000

Behavioural indicators	Most recent year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1994	0.5	0.5	0.5



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of AIDS in Mauritania were found in the literature review carried out. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 7 million and US$ 9 million. This represents a per capita cost of around US$ 3, equivalent to 0.8% of GDP. The current primary school enrolment is 63%. A UNAIDS/UNICEF model developed in 2000 shows that increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. This discontinuity, along with increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in this area, reducing enrolment and, hence, literacy rates. Likewise, the potential impact on other sectors, including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, needs to be carefully monitored in future studies to ensure an appropriate policy response.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 290 000 primary school students, 178 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 7 million and US$ 9 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: But an interim plan, "Plan prioritaire intérimaire," July 1999–December 2000, exists.

Source: NPA

Date: 3 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Other		X

Comments/Key elements:

Source: NPA

Date: 3 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: Some legal aspects of the national response may be found in a circular from the Ministry of Health, "Arrêté ministériel, #72/avril 1998, mettant en place les structures nationales de lutte contre le MST/SIDA".

Source: NPA

Date: 3 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: At ministerial level, a "Comité interministériel de lutte contre le SIDA" made up of central directors.

Source: NPA

Date: 3 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: National strategic plan under development

Source: NPA

Date: 3 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	NA

Comments/Key elements:

Source: NPA

Date: 3 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	NA

Comments/Key elements: AN

Source: NPA

Date: 3 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	2596	UNPOP
Population aged 15–49 (thousands)	1999	1210	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	53	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.3	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	440	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.1	World Bank
Human Development Index rank (HDI)	2000	147	UNDP
% population economically active	-	46.5	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	38	UNESCO
Adult male literacy rate	1995	50	UNESCO
Adult female literacy rate	1995	26	UNESCO
Male secondary school enrolment ratio	1997	21.7	UNESCO
Female secondary school enrolment ratio	1997	11.0	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	40	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	930	WHO
Life expectancy at birth	1998	54	UNPOP
Total fertility rate	1998	5.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	90	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	4	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	40	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	28	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Mauritius

HIV/AIDS epidemiological summary

In 1998, 8% of sex workers tested were HIV-positive. However, there was no evidence of HIV infection among antenatal clinic attendees tested.

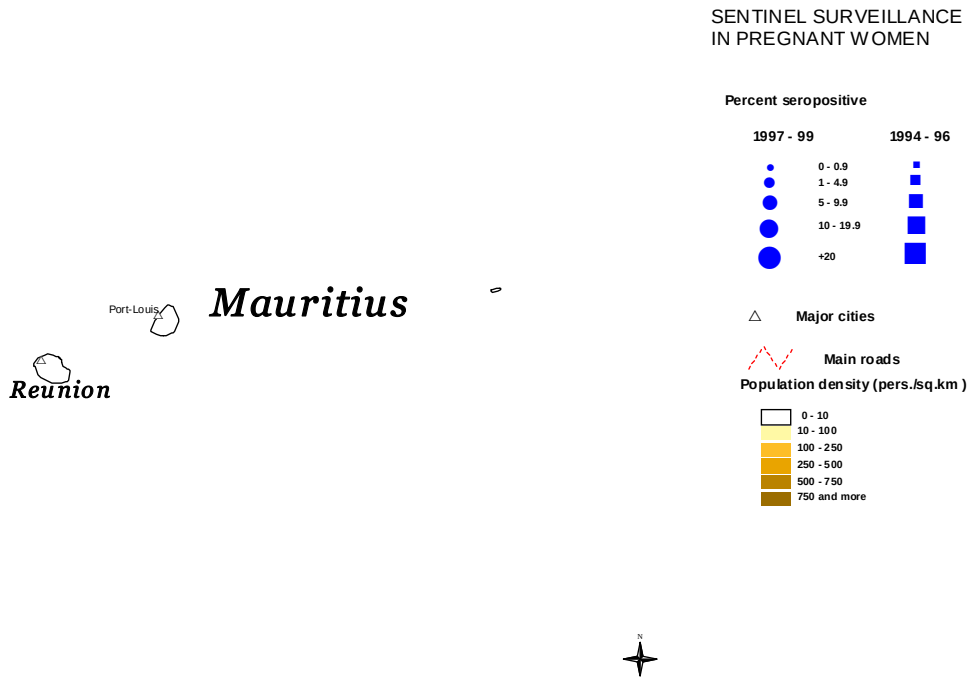
One study reported that, between 1988 and 1991, 1% of STI clinic patients tested HIV-positive but found no evidence of HIV infection among IV drug users.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	500	0.08	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence (%)	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	0.01	0.01	0.01



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of AIDS in Mauritius were found. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US $4 million and US$ 5 million. This represents a per capita cost of around US$ 4 and approximately 0.1% of GDP. In education, a model developed by UNAIDS and UNICEF in 2000 shows that increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. The potential impact on other sectors, including agriculture, households and firms, shown in other African nations to lead to increased costs and expenditure, labour losses, reductions in savings and shifting productivity patterns, needs to be carefully monitored in future studies to ensure an appropriate policy response.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be US$ 4 million - US$ 5 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: 1) Guidelines for Universal Precautions and Infection Control. 2) Guideline on STI treatment (1999). 3) Management Guideline for the Prevention of Mother-to-Child Transmission of HIV (2000). 4) Code of ethics on Care/Counselling of HIV-positive persons (2000).

Source: National AIDS Coordinator

Date: 29 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace	X	
Sports	X	
Others		

Comments/Key elements:

Source: National AIDS Coordinator

Date: 29 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: National Children's Council Act and the National Women's Council Act provide general protection to these vulnerable groups.

Protection of Human Rights Act was enacted in December 1998 and proclaimed in January 1999.

Source: National AIDS Coordinator

Date: 29 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A National AIDS Committee was established in the Ministry of Health as a multisectoral body in 1987. It provides the policy guideline to the National Programme.

Source: National AIDS Coordinator

Date: 29 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: National Strategic Plan 2001-2005 is currently under preparation.

Source: National AIDS Coordinator

Date: 29 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

Suggested priority areas are as follows:

- Educational activities focusing on general population and specific vulnerable groups;
- Care and support of people living with HIV/AIDS;
- Training of peer educators, medical personnel and community workers;
- Operational research.

Source: National AIDS Coordinator

Date: 29 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Implementation of the National AIDS Control Programme depends on external funds.

Source: National AIDS Coordinator

Date: 29 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	1150	UNPOP
Population aged 15–49 (thousands)	1999	661	UNPOP
Annual population growth (%)	1990–1998	1.0	UNPOP
% of population urbanized	1998	40	UNPOP
Average annual growth rate of urban population (%)	1990–1998	1.0	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	3870	World Bank
GNP per capita average annual growth rate (%)	1996-1997	3.9	World Bank
Human Development Index rank (HDI)	2000	71	UNDP
% population economically active	-	-	-
Unemployment rate	1995	9.8	ILO
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	83	UNESCO
Adult male literacy rate	1995	87	UNESCO
Adult female literacy rate	1995	79	UNESCO
Male secondary school enrolment ratio	1996	63.3	UNESCO
Female secondary school enrolment ratio	1996	65.7	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	16	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	6	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	120	WHO
Life expectancy at birth	1998	72	UNPOP
Total fertility rate	1998	1.9	UNPOP
Infant mortality rate (per 1000 live births)	1999	15	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	75	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	97	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	90	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Morocco

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available from Morocco since 1990. Agadir, Casablanca, Marrakech, Rabat and Tanger are considered major urban areas. No evidence of HIV infection was found among this group until 1993 when 0.2% of antenatal women in Rabat tested HIV-positive. In 1997, however, there was no evidence of HIV infection among antenatal clinic women tested in Agadir, Casablanca or Marrakech. Nor was there evidence of HIV infection among antenatal clinic women tested in Safi, Fès, Meknès, Oujda or Tétouan in 1996 and 1997.

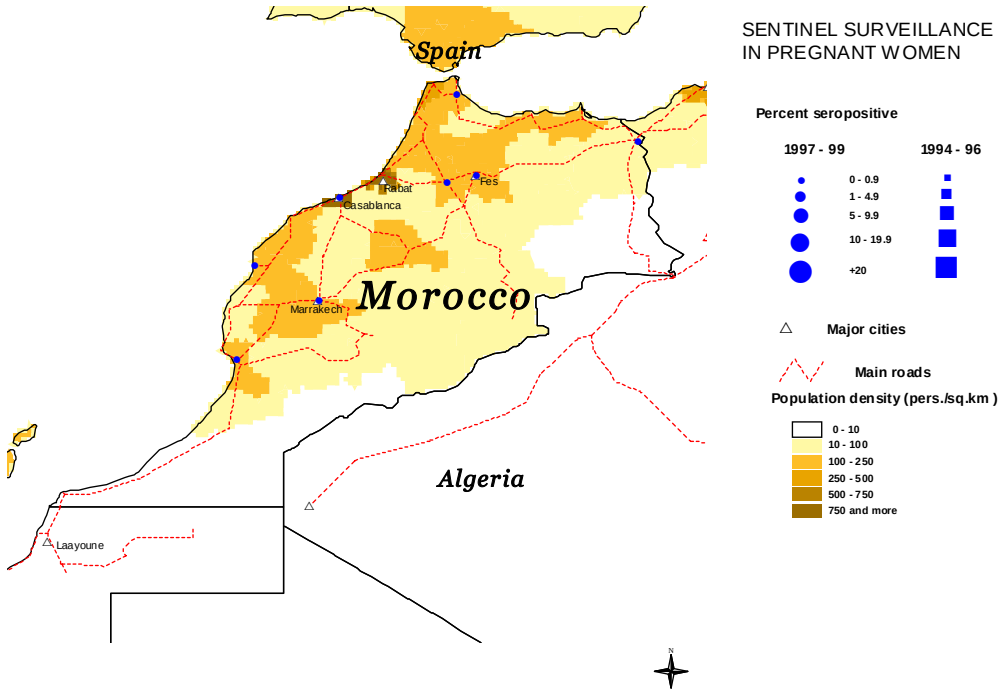
In 1997, a median of 1% of STI clinic patients in Agadir, Casablanca, Marrakech, Rabat and Tangier tested HIV–positive. Outside of the major urban areas, there was no evidence of HIV infection among STI clinic patients tested in Oujda, Meknès, Safi, Tétouan and Fès in 1996. However, in 1997, 1% of STI clinic patients in Oujda and Tétouan tested HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	5000	0.03	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	UNAIDS/WHO, June 2000
Estimated AIDS deaths	-	-	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	0.0	0.0	0.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

As with many of the countries of Northern Africa, no data on the economic impact of AIDS in Morocco were available. With the prevalence of AIDS in these areas at a low level, the impact is mostly felt in the health sector and at the household level. Data are required in order for us to understand the current level of demand on the health sector and the future costs. In households, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. Again, studies are required for an understanding of the nature of the epidemic's effect. Information in these areas can help shape policy responses appropriately so that the extent of the epidemic's impact is minimized.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	27 867	UNPOP
Population aged 15–49 (thousands)	1999	15 284	UNPOP
Annual population growth (%)	1990–1998	1.7	UNPOP
% of population urbanized	1998	52	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.8	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	1260	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-3.9	World Bank
Human Development Index rank (HDI)	2000	124	UNDP
% population economically active	-	36.0	ILO
Unemployment rate	1996	17.8	ILO
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	44	UNESCO
Adult male literacy rate	1995	57	UNESCO
Adult female literacy rate	1995	31	UNESCO
Male secondary school enrolment ratio	1996	44.4	UNESCO
Female secondary school enrolment ratio	1996	33.9	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	25	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	7	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	610	WHO
Life expectancy at birth	1998	67	UNPOP
Total fertility rate	1998	3.0	UNPOP
Infant mortality rate (per 1000 live births)	1999	48	UNPOP/UNICEF
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	-	-	-

References

Mozambique

HIV/AIDS epidemiological summary

HIV sentinel surveillance of antenatal clinic attendees began in Maputo, a major urban area, in 1988. HIV prevalence increased from less than 1% in 1988 to 10% in 1998 among antenatal clinic attendees tested. In 1998, Manhica was added to the sentinel surveillance as a major urban site where 13% of antenatal clinic women tested positive. Age detail is available from 1988 to 1998 for various years. HIV prevalence among antenatal clinic women less than 20 years of age rose from 1% in 1988 to 9% in 1998. HIV prevalence information on antenatal clinic attendees outside of the major urban areas has been available since 1992 and the number of sites has increased from 1 to 6. In 1992, no evidence of HIV infection was found among women tested in Vilanculos. In 1994, a median of 11% of antenatal clinic attendees tested in Nacala, Chimoio and Tete were HIV-positive. These three areas are near the borders of Zambia and Zimbabwe where high levels of HIV prevalence have been reported. In 1998, 17% of antenatal clinic women tested in 6 sites were HIV-positive. Detailed age data are available from Beira, Tete and Chimoio for 1998. Twenty per cent of antenatal clinic women less than 20 years of age tested HIV-positive.

There is no information available on HIV prevalence among sex workers in Mozambique.

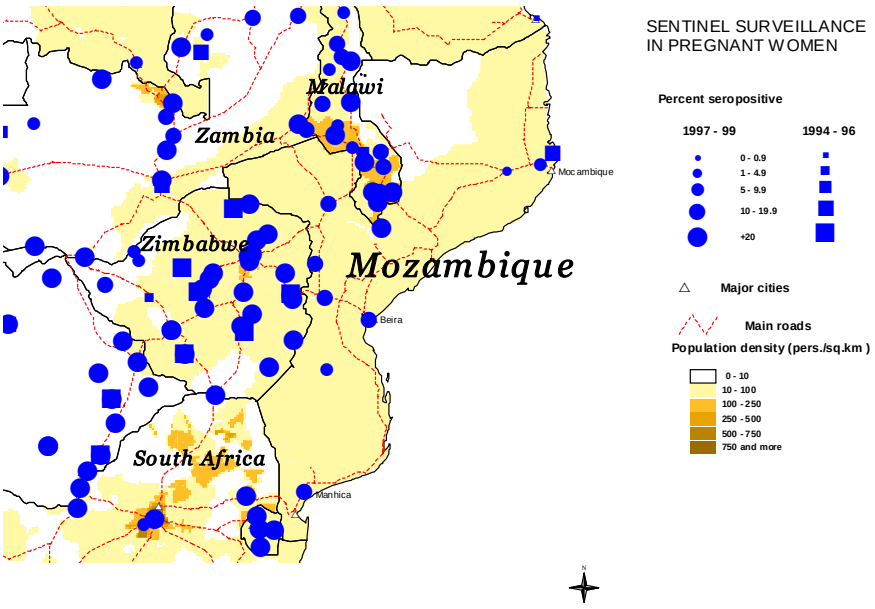
Between 1987 and 1996, HIV prevalence among male STI clinic patients tested in Maputo increased from 3% to 20%. Among female STI clinic patients tested in Maputo, HIV prevalence increased from 5% in 1993 to 8% in 1997. Outside of Maputo, HIV prevalence among male STI clinic patients tested was 37% in 1998 and 26% among female STI clinic patients in 1997.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	1 200 000	1 100 000	13.22	630 000	52 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	310 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	98 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1997	15–49	28.0	19.0
Reported non-regular sexual partnership over a 12-month period (%)	1997	15–49	37.0	14.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	11.2	9.9	12.5



Economic impact of HIV/AIDS

Economic impact of HIV/AIDS summary

No empirical data on the economic impact of HIV/AIDS on Mozambique were found in the literature review. Only international studies using models to explore the effect of AIDS on the education and health systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, more detailed studies are required to understand the full impact. An education model developed by UNAIDS and UNICEF shows that increasing mortality rates due to AIDS lead to discontinuity, with many pupils losing or having a change in their teachers. In the health sector there are still extensive investments required to scale-up AIDS programmes equivalent to US$ 2–4 per capita and 2.7% of GDP. Data are also required for an understanding of how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 1.5 million primary school students, 20 000 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 47 and US$ 76 million (2)

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: The development of a National Policy on HIV/AIDS is in process.

Source: UNAIDS Mozambique

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: Not available

Source: UNAIDS Mozambique

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: Two proposals are currently being developed, i.e. on HIV/AIDS test regulation and on HIV/AIDS in the workplace.

Source: UNAIDS Mozambique

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

A National AIDS Council was established in May 2000 as an independent institution representing the national coordinating body for the fight against STI/HIV/AIDS in Mozambique. Chair: Prime Minister; Vice Chair: Minister of Health. Composition: eight ministers, five from NGOs (rotating membership of project managers from dynamic projects), three from religious organizations and celebrities (rotating membership).

A Secretariat for the National AIDS Council is currently being set up with an Executive Secretary and four senior professionals (economist, gender specialist, communication specialist and a public health epidemiologist).

Source: UNAIDS Mozambique

Date: May 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements:

- A multisectoral National Strategic Plan to combat STD/HIV/AIDS (2000-2002) was completed in September 1999 and approved by government in February 2000.
- Provincial plans will be produced for each province. So far, plans have been produced in five provinces.
- Plans will also be produced for each sectoral ministry. At this stage, there are sectoral plans in the education and health sectors only.
- Although no plans are in place yet, there are existing programmes on STD/HIV/AIDS in every province and activities are extended to district level under a new integrated plan on communicable diseases and epidemiology.

Source: UNAIDS Mozambique

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

During the period 2000–2002, priority will be given to the following activities:

- The implementation of essential activities to prevent infection, directed towards young people, particularly girls, highly mobile individuals and those who resort to commercial sex.
- Implementation of essential activities to reduce impact, aimed at orphans and people living with HIV/AIDS.
- Improving the quality and coverage of the following programmes of essential activities: youth-to-youth education, STI diagnosis and treatment, counselling and voluntary tests and treatment of opportunistic diseases.
- Implementation of activities in the central, northern and southern corridors.

Essential activities for prevention: Promotion/use of condoms, sex education, STI treatment, counselling and voluntary testing, informing young people about health services, strengthening girls'/women's negotiation power, mobilization of communities linked to vulnerable priority groups.

Essential activities for impact reduction: Counselling and voluntary testing, condom counselling, treatment of opportunistic diseases in centres, e.g. day hospitals, domiciliary care, vocational training, income-generating activities.

Source: UNAIDS Mozambique/National Strategic Plan to combat STD/HIV/AIDS 2000-2002, Government of Mozambique, 1999.

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements:

Source: UNAIDS Mozambique

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	19 286	UNPOP
Population aged 15-49 (thousands)	1999	8 632	UNPOP
Annual population growth (%)	1990-1998	3.6	UNPOP
% of population urbanized	1998	35	UNPOP
Average annual growth rate of urban population (%)	1990-1998	7.0	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	140	World Bank
GNP per capita average annual growth rate (%)	1996-1997	10.5	World Bank
Human Development Index rank (HDI)	2000	168	UNDP
% population economic active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	40	UNESCO
Adult male literacy rate	1995	58	UNESCO
Adult female literacy rate	1995	23	UNESCO
Male secondary school enrolment ratio	1996	9.0	UNESCO
Female secondary school enrolment ratio	1996	5.7	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	43	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	20	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1500	WHO
Life expectancy at birth	1998	44	UNPOP
Total fertility rate	1998	6.2	UNICEF
Infant mortality rate (per 1000 live births)	1999	115	UNICEF/UNIPOP
Contraceptive prevalence rate (%)	1990-1999	10	UNICEF/UNPOP
% of births attended by trained health personnel	1990-1999	44	UNICEF
% of one-year-old children fully immunized-DPT	1995-1998	77	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for sub-Saharan Africa*. Draft report, April 2000.

Namibia

HIV/AIDS epidemiological summary

Four national sentinel surveys have been conducted among antenatal clinic attendees in Namibia since the early 1990s. Windhoek and Walvis Bay are the major urban areas, but data are only available from Walvis Bay for 1998. HIV prevalence among antenatal clinic attendees tested increased from 4% in 1991-92 to 26% in 1998.

Outside of the major urban areas, HIV prevalence information among antenatal women is available from eight sites in 1991-92 and increases to 13 sites by 1998. Median HIV prevalence among antenatal women increased from 3% in 1991–92 to 15% in 1998. From the 13 sentinel sites in 1998, HIV prevalence among antenatal women tested ranged from 6% to 34%. HIV prevalence among 15–19-year-olds tested in all the sites, including Windhoek, increased from 6% in 1994 to 12% in 1998. Among 20–24-year-olds, HIV prevalence increased from 11% in 1994 to 20% in 1998.

There is no information available on HIV prevalence among sex workers.

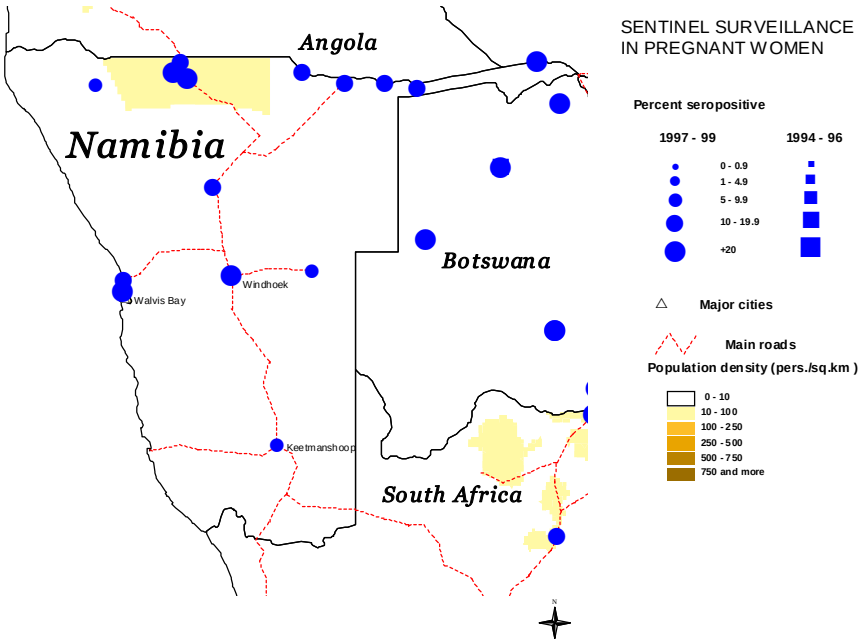
In 1998, a median of 42% of STI clinic patients tested in Windhoek and Walvis Bay were HIV-positive. Median prevalence from the 11 sites outside of the major urban areas was 34% of STI clinic patients tested in 1998. Prevalence ranged from 10% to 61%.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	160 000	150 000	19.54	85 000	6600

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	67 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	18 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	25.9	22.7	29



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Namibia are limited. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is substantial. Impact at the household level is shown by a reduction in savings in AIDS-affected households and increased costs. The impact on agricultural production is evident through the observed reduction in production time. No data were found on the impact on businesses but it is likely that firms are already facing rising costs in order to cover employees' AIDS-related medical and funeral expenses. In the public sectors, an education model, drafted by UNAIDS and UNICEF in 2000, shows how increasing mortality rates due to AIDS lead to discontinuity, with many pupils losing or changing their teachers. In the health sector, there are still extensive investments required to scale-up AIDS programmes equivalent to US$ 4-5 per capita and 0.3% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimates the annual loss in GDP growth per capita as a result of AIDS to be 1.5% by 2010 (1).

Economic impact of HIV/AIDS on households

Household savings were seen to decline in the form of a reduction in livestock numbers in 12 of 18 AIDS-affected households surveyed (2).

Economic impact of HIV/AIDS on agriculture

Mourning may lead to up to 25% loss of production time during short critical production periods (e.g. sowing and weeding) (2).

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of approximately 350 000 primary school students, 9500 would have lost a teacher to AIDS in 1999 (3).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: The annual cost of care consumed 2.9% of the allocated health budget in 1996 and is projected to consume between 13% and 17% of the total health budget in 2001 (4);

Resource gap: In 2000, the annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 6 million and US$ 9 million (5).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: Not available

Source: UNAIDS Namibia

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports	X	
Others	X	

Comments/Key elements: Not available

Source: UNAIDS Namibia

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: There is a Draft Policy on Confidentiality, Notification, Reporting and Surveillance.

Source: UNAIDS Namibia

Date: June 2000

Organizational structure

High-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

- The National AIDS Coordination Programme (NACOP), which was launched by the President in March 1999, is under the leadership of the Ministry of Health and Social Services (MOHSS).
- The National AIDS Committee, chaired by the Minister of Health and Social Services and co-chaired by the Minister of Local Government and Housing, is comprised of ministers from all sectors, and is intended to be the key policy-making body on HIV/AIDS.
- The National Multisectoral Committee on HIV/AIDS (NAMACOC*)* is chaired by the Permanent Secretary of the MOHSS and includes Regional Governors, permanent secretaries from all key ministries, representatives from NGOs, the private sector and the UN system (UN Resident Coordinator, Theme Group Chairperson and the Country Programme Adviser).
- The National AIDS Executive Committee (NAEC*),* is the key implementing body, and is chaired by the Under-Secretary of the MOHSS.

Source: UNAIDS Namibia

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The National Strategic Plan (MTP II, 1999-2004) was completed in 1998 and officially launched in March l999.

Source: UNAIDS Namibia

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Eight major strategies, 89 targets, and hundreds of key activities with participation of all sectors have been identified. Decentralization of responsibility through the offices of the Regional Governors is a key component.

A considerable amount of work is currently under way to develop the implementation plan which aims to address prioritization of current and planned activities within each sector at both the central and the regional level.

Source: UNAIDS Namibia

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
x	

Comments/Key elements: Budget – N$ 21 377 900

Source: UNAIDS Namibia

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	1695	UNPOP
Population aged 15-49 (thousands)	1999	795	UNPOP
Annual population growth (%)	1990-1998	2.6	UNPOP
% of population urbanized	1998	37	UNPOP
Average annual growth rate of urban population (%)	1990-1998	4.8	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	2,110	World Bank
GNP per capita average annual growth rate (%)	1996-1997	-1.3	World Bank
Human Development Index rank (HDI)	2000	115	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	-	-	-
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	1996	56.3	UNESCO
Female secondary school enrolment ratio	1996	66.2	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	35	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	370	WHO
Life expectancy at birth	1998	51	UNPOP
Total fertility rate	1998	4.9	UNPOP
Infant mortality rate (per 1000 live births)	1990	68	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990-1999	29	UNICEF/UNPOP
% of births attended by trained health personnel	1990-1999	68	UNICEF
% of one-year-old children fully immunized-DPT	1995-1998	74	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Engh, I. D., Stloukal, L., and du Guerny, J. *HIV/AIDS in Namibia: the impact on the livestock sector*. Rome, UN Food and Agriculture Organization, 2000.

(3) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(4) UNDP and UNAIDS. *Namibia: Human Development Report 1997*. Namibia, UNDP, 1997.

(5) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Niger

HIV/AIDS epidemiological summary

HIV surveillance information on antenatal clinic women has been available from Niger since 1987–88. Niamey is considered the only major urban area. HIV prevalence among antenatal clinic women increased from 0.5% in 1987–88 to 1% in 1993; more recent data are unavailable. Outside Niamey, HIV prevalence information is available from Maradi, where nearly 1% of antenatal clinic women tested positive for HIV-1 and/or HIV-2 in 1990, from Tahoua in 1992, and from Zinder in 1992 and 1994, where HIV-1 prevalence ranged from 0 to 1%.

HIV-1 prevalence rates among sex workers in Niamey increased from 6% in 1987–88 to nearly 24% in 1997. Outside Niamey, in 1988, 4% of sex workers tested in Arlit were HIV-1 and/or HIV-2-infected. In 1989, 9% of sex workers in Maradi tested HIV-1-positive. By 1994, 34% of sex workers in Dirkou tested HIV-positive.

In 1991-92, 4-5% of STI clinic patients in Niamey tested HIV-positive.

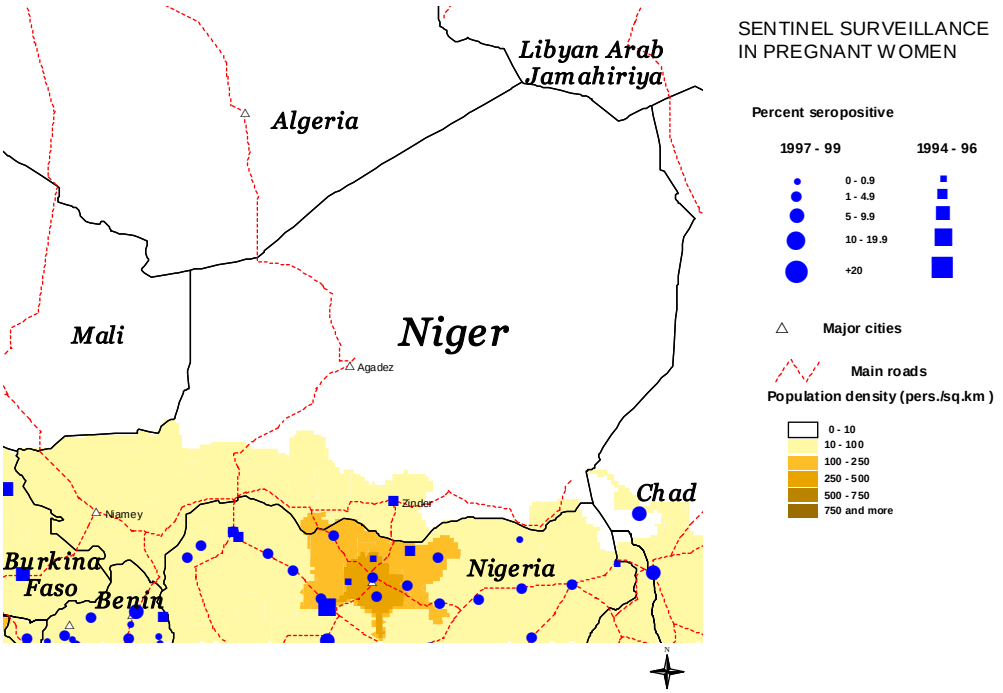
In Niamey, a study of truck drivers and their apprentices reported that 3% tested HIV-1-positive in 1993.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	64 000	61 000	1.35	34 000	3300

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	31 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	6500	UNAIDS/WHO; June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1998	15-59	1.9	-
Reported non-regular sexual partnership over a 12-month period (%)	1998	15-59	9.9	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1993	1.3	1.3	1.3



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Niger were found in the literature review. Only international studies using models to explore the effect of AIDS on the education and health systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. In businesses, more detailed studies are required in order for us to understand the full impact. In education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Data are also required for an understanding of how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers. One study demonstrates that the extensive investments required to scale-up AIDS programmes are equivalent to US$ 3 per capita and 1.9% of GDP.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 480 000 primary school students, 820 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 26 million and US$ 36 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	NA

Comments/Key elements: Not available

Source: CPA

Date: 22 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: CPA

Date: 22 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: Under development.

Source: CPA

Date: 22 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 22 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	10 400	UNPOP
Population aged 15–49 (thousands)	1999	4509	UNPOP
Annual population growth (%)	1990–1998	3.3	UNPOP
% of population urbanized	1998	19	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.3	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	200	World Bank
GNP per capita average annual growth rate (%)	1996–1997	0.0	World Bank
Human Development Index rank (HDI)	2000	173	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	14	UNESCO
Adult male literacy rate	1995	21	UNESCO
Adult female literacy rate	1995	7	UNESCO
Male secondary school enrolment ratio	1996	8.9	UNESCO
Female secondary school enrolment ratio	1996	4.8	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	48	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	16	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1200	WHO
Life expectancy at birth	1998	49	UNPOP
Total fertility rate	1998	6.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	112	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	8	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	18	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	22	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Nigeria

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available since the mid-1980s; however, reporting from more than one or two sites per year did not begin until 1991–92. By 1993–94, 10 major urban sites reported HIV prevalence among antenatal clinic women, though it remained low for many years. But, by 1988–90, 1% of antenatal women in the major urban areas tested positive for HIV; by 1993–94, a median of nearly 4% in major urban areas tested positive; in 1999, nearly 5% did so. Among the 10 major urban sites in 1999, HIV prevalence ranged from 3% to 8% of antenatal women tested.

By 1991–92, 20 sites from 10 states outside major urban areas reported HIV prevalence from sentinel surveillance of antenatal women. This rose to 63 sites in 1999. Median HIV prevalence among antenatal women tested at these sites increased from less than 1% in 1991–92 to 5% in 1999. The range of HIV prevalence rates in 1999 went from less than 1% to 21% of antenatal women tested. HIV prevalence among antenatal women by age is available for the six regions. In 1999, peak infection occurred among women under 25, of whom 6% tested HIV-positive.

There is some limited information available on HIV prevalence among sex workers, from the mid-1980s. Testing of sex workers in Lagos began in 1988–89. Two per cent of sex workers tested at that time were HIV-positive, rising to 12% in 1990–91. By 1993–94, 30% of sex workers tested were HIV-positive.

In 1986, less than 1% of sex workers in Borno State tested HIV-positive; by 1989-90, 4% did so. In 1991-92, seven sites outside the major urban centres were reporting information on HIV prevalence among sex workers. At that time, a median of 13% of sex workers tested HIV-positive, the prevalence among these sites ranging from no evidence of HIV infection to 44%. By 1995–96, 15 sites were reporting a range of prevalence among tested sex workers of 7% to nearly 70%.

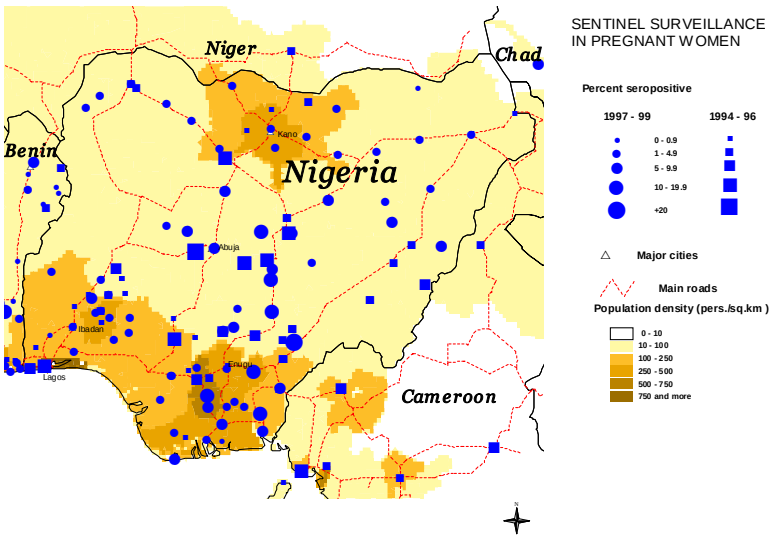
By 1994, 5% of STI clinic patients tested in the major urban areas were HIV-positive. HIV prevalence from 21 sites outside of the major urban areas increased from 7% of STI clinic patients tested in 1993–94 to 12% in 1995–96. HIV prevalence ranged from 1% to 70% of STI patients tested in 1995–96. In 1993-94, 4% of long-distance truck drivers tested in Anambra State were HIV-1-infected.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	2 700 000	2 600 000	5.06	1 400 000	120 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	1 400,000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	250 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1999	4.5	2.7	8



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact on Nigeria are limited. A recently developed model has predicted that the impact on economic growth is potentially larger than the average rate in sub-Saharan Africa. Of the sectors explored here, the studies in health demonstrate that there is a large gap in funding to meet the full needs of a scaled-up care and prevention programme. This would cost approximately US$ 2–3 per capita or approximately 0.8% of GDP. In education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. The potential impact on other sectors, including agriculture, households and firms, shown in other African nations to lead to increased costs and expenditure, labour losses, reductions in savings and shifting productivity patterns, needs to be carefully monitored in future studies.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimates the annual loss in GDP growth per capita as a result of AIDS to be 0.95% by 2010 (1).

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 14.8 million primary school students, 85 000 would have lost a teacher to AIDS in 1999 (2).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: 1-2% of teaching hospital beds are occupied by AIDS patients (3).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 229 million and US$ 329 million (4).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements:

Source: CPA

Date: 26 June 2000.

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military	X	
Workplace		X
Sports		X
Others		X

Comments/Key elements: Some private sectors have policy document (e.g. petroleum companies).

Source: CPA

Date: 26 June 2000.

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: CPA

Date: 26 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A Presidential Commission on AIDS composed of representatives of technical ministries.

Source: CPA

Date: 26 June 2000.

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: National Strategic Plan under development. Situation and response analysis done. Interim action plan under elaboration.

Source: CPA

Date: 26 June 2000.

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: NA

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: NA

Source: CPA

Date: 26 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	106 945	UNPOP
Population aged 15–49 (thousands)	1999	50 555	UNPOP
Annual population growth (%)	1990–1998	2.5	UNPOP
% of population urbanized	1998	41	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.4	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	280	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.1	World Bank
Human Development Index rank (HDI)	2000	151	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	57	UNESCO
Adult male literacy rate	1995	67	UNESCO
Adult female literacy rate	1995	47	UNESCO
Male secondary school enrolment ratio	1996	37.0	UNESCO
Female secondary school enrolment ratio	1996	31.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	36	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	15	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1000	WHO
Life expectancy at birth	1998	50	UNPOP
Total fertility rate	1998	5.1	UNPOP
Infant mortality rate (per 1000 live births)	1999	80	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	6	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	31	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	21	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(3) Special Report, THISDAY. *The Sunday Newspaper* 1999; 31.

(4) UNAIDS and World Bank. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Rwanda

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Rwanda since the late 1980s. In Kigali, the major urban area, 32% of antenatal clinic attendees tested in 1988 were HIV-positive. HIV prevalence has ranged between 25% and 33% among antenatal clinic attendees in Kigali through 1995. In 1997, HIV prevalence ranged from 10% to 28% among antenatal clinic women tested at two sites. HIV information by age is available for 1989, 1991 and 1992–93. Peak HIV prevalence of over 35% was seen among 20–24-year-old antenatal clinic attendees in both 1989 and 1992–93.

Outside Kigali, HIV prevalence among antenatal clinic attendees ranged from 1% to 23% from 1989–90 to 1997. In 1996, HIV prevalence among antenatal attendees tested in 6 sites outside Kigali ranged from 4% to 17%, with peak prevalence being found among the 20–29-year-old antenatal attendees.

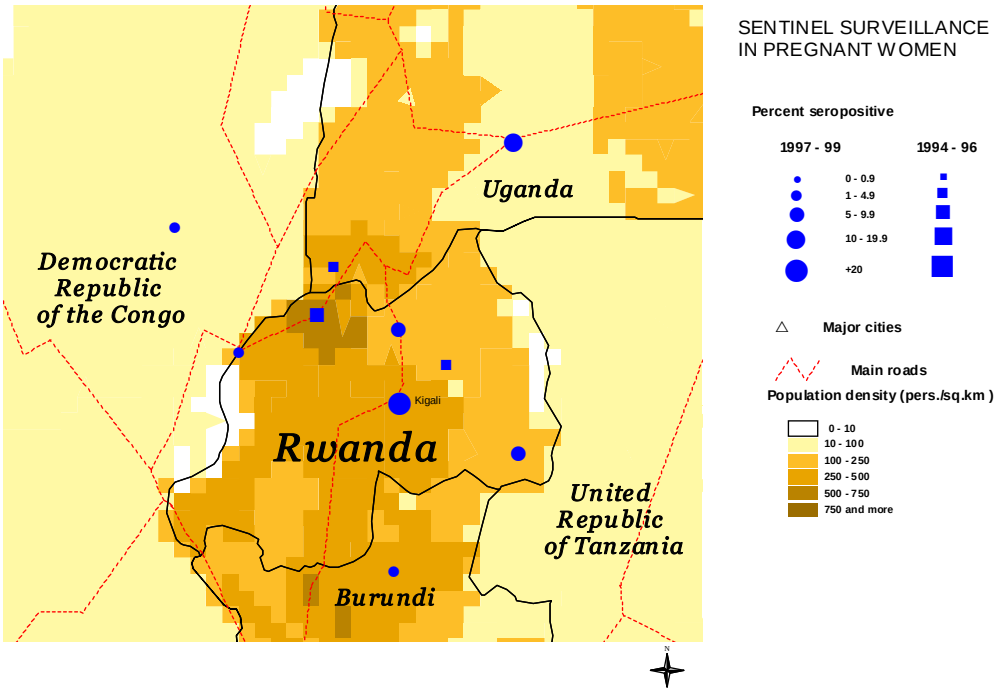
Information on HIV prevalence among male STI clinic patients has been available from Kigali since 1986. HIV prevalence reached 55% among male STI clinic patients tested in 1988–1990. In 1996, 29% of STI clinic patients tested in Kigali and 55% of patients in Biryogo were HIV-positive. Among female STI clinic patients tested, HIV prevalence ranged from 69% to 77% between 1986 and 1991.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	400 000	370 000	11.21	210 000	22 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	270 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	40 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	19.0	10.0	28.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

The data on the economic impact of HIV/AIDS in Rwanda are limited and, in many cases, out of date. For the most part, evidence has been obtained from international studies that model the impact of the epidemic on the economy as a whole, on the education sector, and on the resource gap in health service provision. With the instability of such a war-torn nation, it is likely that the prevalence of AIDS is rising fast, the impact of which will be felt in each of the sectors identified here. At the household level, a recent survey shows the dramatic impact on wealth through the necessity to borrow or sell assets. In agriculture, a model predicted a reduction in production in rural households. In the business sector, it is likely that illness and death lead to declines in net profits as a result of increased costs, reduced savings and shifts in productivity patterns. In education, a model developed by UNAIDS and UNICEF shows how the increasing mortality due to AIDS leads to discontinuity, with many pupils losing or having a change in their teachers. Data are required to enable us to understand how supply of health services might be affected by rising infection rates in health care workers. On the demand side, a recent study shows the increased demand for outpatient services from people living with AIDS. Further, there are still extensive investments required to scale-up AIDS programmes, equivalent to US$ 3–US$ 4 per capita and 1.7% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimates the annual loss in GDP growth per capita as a result of AIDS to be 0.7% by 2010 (1).

Economic impact of HIV/AIDS on households

In a survey of people living with AIDS at four health facilities in 1998, less than 30% of households were able to meet the costs of health care using their own resources (2).

Economic impact of HIV/AIDS on agriculture

An early, pre-crisis survey estimated that 25% of rural households would be affected by productivity losses as a result of AIDS by 2000 (3).

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 1.1 million primary school students, 15 000 would have lost a teacher to AIDS in 1999 (4).

Economic impact on the health sector

Supply: Not available

Demand: A study of four health facilities found annual per capita outpatient use of 10.92 visits for people living with AIDS, as compared with 0.29 in the general population (2). A 1990 model showed the total cost of AIDS patients in 1990 to be US$ 0.6 million or 4.6% of the public sector health budget. The cost was projected to reach 11.4% of the public sector budget in 1994 (5).

Resource gap: In 2000, the annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 22 million and US$ 32 million (1).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Rwanda

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: UNAIDS Rwanda

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Rwanda

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: A CNLS is in preparation

Source: UNAIDS Rwanda

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: Not available

Source: NACP

Date: 1998-2001

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: 14 areas have been identified as a priority

Source: UNAIDS Rwanda

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: The plan is budgeted and different donors are playing a role. The government increased its contribution by a factor of five.

Source: UNAIDS Rwanda

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	7235	UNPOP
Population aged 15–49 (thousands)	1999	3338	UNPOP
Annual population growth (%)	1990–1998	-0.7	UNPOP
% of population urbanized	1998	6	UNPOP
Average annual growth rate of urban population (%)	1990–1998	0.9	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	210	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-5.5	World Bank
Human Development Index rank (HDI)	2000	164	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	61	UNESCO
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	1996	14.9	UNESCO
Female secondary school enrolment ratio	1996	11.5	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	41	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1300	WHO
Life expectancy at birth	1998	41	UNPOP
Total fertility rate	1998	6.1	UNPOP
Infant mortality rate (per 1000 live births)	1999	121	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	21	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	26	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	77	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Nandakumar, A. K., Schneider, P., and Butera, D. *Use of and Expenditures on Outpatient Health Care by a Group of HIV-positive individuals in Rwanda*. Paper presented to the International AIDS Symposium Economic Network, Durban, South Africa, 7-8 July 2000.

(3) Gillespie, S. Potential impact of AIDS on farming systems: a case study from Rwanda. *Land Use Policy* 1989; 6:301-12.

(4) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(5) Shepherd, D.S., Bail, R.N., Bucyendore. Costs of AIDS care in Rwanda. *Intl Conf AIDS* 1992; 8(2):D471.

Sao Tome and Principe

HIV/AIDS epidemiological summary

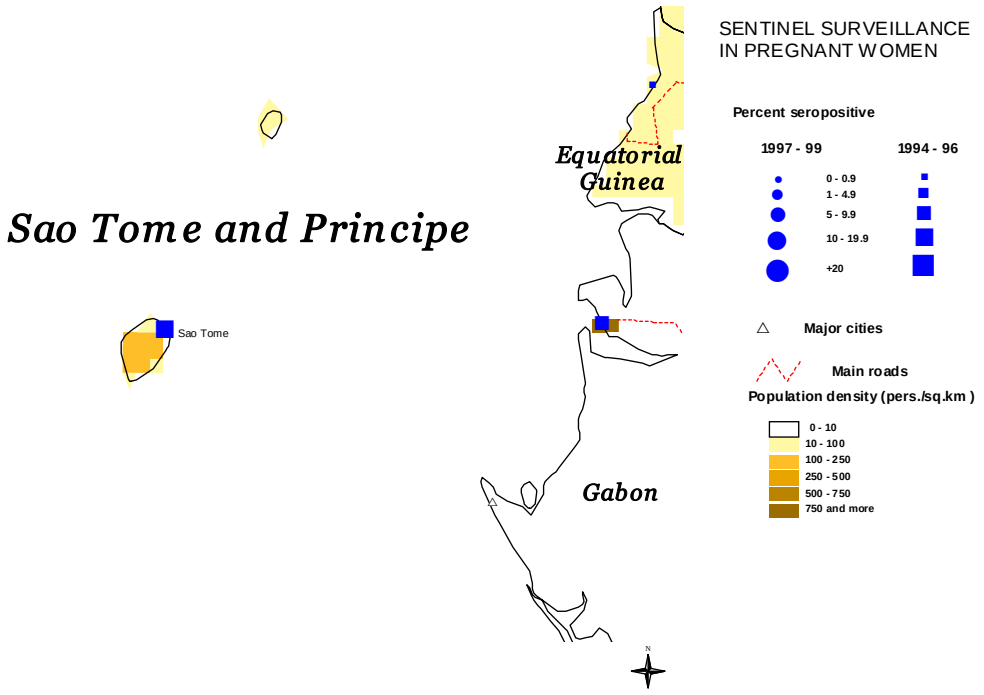
In Sao Tome, HIV prevalence among pregnant women increased from 0.6% in 1989 to 12% in 1994–1995. No data are available for more recent years or for other groups of the population.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
-	-	-	-	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Most recent year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Not available

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others, prisons and immigration		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

Not available

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	144	UNPOP
Population aged 15–49 (thousands)	-	-	-
Annual population growth (%)	1990-1999	2.2	WHO
% of population urbanized	1999	46	UNPOP
Average annual growth rate of urban population (%)	1995-2000	3.7	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1998	270	UNDP
GNP per capita average annual growth rate (%)	1990-1998	-1.1	UNDP
Human Development Index rank (HDI)	2000	132	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-

Education indicators	Year	Estimate	Source
Total adult literacy rate	1998	57	UNDP
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	-	-	-
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	-	-	-
Crude death rate (deaths per 1000 pop.)	-	-	-
Maternal mortality rate (per 100 000 live births)	-	-	-
Life expectancy at birth	1998	64	UNDP
Total fertility rate	1999	6.1	WHO
Infant mortality rate (per 1000 live births)	1998	60	UNDP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized (DPT)	-	-	-

References

Senegal

HIV/AIDS epidemiological summary

HIV-1 and HIV-2 surveillance information on antenatal clinic women has been available from Senegal since the mid-1980s. In Dakar, the major urban area in Senegal, HIV-1 prevalence among antenatal clinic women has been 1% or less for all years up to 1998. In only two years—1990 and 1995—1% of antenatal clinic women tested positive for HIV-1 and, in 1998, 0.5% of women tested positive. Outside the major urban areas, HIV-1 prevalence among antenatal clinic women has also remained low, ranging from 0% and 0.8% between 1986 and 1998. HIV-2 prevalence in Dakar decreased from almost 2% in 1990 to 0% in 1997. Outside Dakar, HIV-2 prevalence ranged from 0.2% to 1.7% in 1997.

Although HIV-1 prevalence has remained very low among antenatal clinic women in Dakar, prevalence among sex workers has increased gradually from less than 1% in 1986 to 13% in 1995. Since then, HIV-1 prevalence has declined and, in 1998, 7% of sex workers tested were HIV-1-positive. HIV-1 prevalence among sex workers outside of Dakar, in Kaolack and Ziguinchor, continues to increase, from 0% in 1986 and 1989 to 20% in 1998.

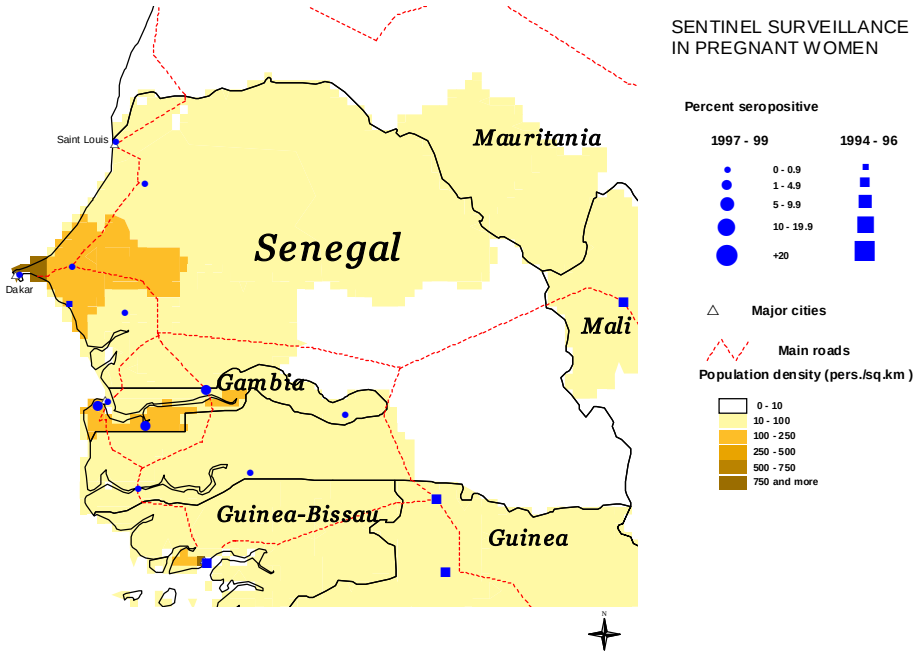
Since 1989, HIV-1 prevalence among male STI clinic patients in Dakar increased from 1% to nearly 5% in 1993. In 1998, 3% of male STI clinic patients tested positive for HIV-1 or HIV-1+2. Outside Dakar, HIV-1 prevalence among male STI clinic patients increased from no evidence of HIV infection in 1989 to 3% in 1994.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	79 000	76 000	1.77	40 000	3300

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	42 000	UNAIDS/WHO June, 2000
Estimated AIDS deaths	1999	7800	UNAIDS/WH0, June, 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1998	13–62	58.0	82.0
Reported non-regular sexual partnership over a 12-month period (%)	1998	18–62	23.0	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	0.5	0.5	0.5



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of AIDS in Senegal were found in the literature review carried out. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 30 million and US$ 50 million. This represents a per-capita cost of around US$ 3 – US$ 5 and 1.1% of GDP. In the education sector, the current primary school enrolment is 60%. A model developed by UNAIDS and UNICEF shows how increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. This discontinuity, along with the burden of school fees, increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in this area, reducing enrolment and, hence, literacy rates. Likewise, the potential impact on other sectors, including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, needs to be carefully monitored in future studies (1)(2).

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 900 000 primary school students, 2000 would have lost a teacher to AIDS in 1999 (3).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to range from US$ 30 million to US $50 million.

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: "Programme national de lutte contre le SIDA", issued in 1986, includes a political declaration and strategic interventions. But the document needs to be updated to include current priorities: mother-to-child transmission, voluntary counselling and testing.

Source: WHO Focal Point

Date: 3 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: There are no sectoral strategy documents. Sectoral interventions focus on prevention as an activity in support of public health.

Source: WHO Focal Point

Date: 3 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: WHO Focal Point

Date: 3 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: "Comité Interministériel de Lutte contre le SIDA" is an Inter-Ministerial Committee in charge of coordinating the national response. This committee needs to be strengthened.

Source: WHO Focal Point

Date: 3 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The current National Strategic Plan runs until 2001.

Source: WHO Focal Point

Date: 3 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Priorities are the following: blood transfusion security, vulnerable groups, voluntary counselling and testing, mother-to-child transmission, surveillance, access to therapy, PLWHA, STI, IEC and behavioural change.

Source: WHO Focal Point

Date: 3 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Three financial sources are considered: the state, local authorities and development partners.

Source: WHO Focal Point

Date: 3 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	9240	UNPOP
Population aged 15–49 (thousands)	1999	4262	UNPOP
Annual population growth (%)	1990–1998	2.6	UNPOP
% of population urbanized	1998	44	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.8	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1998	520	UNDP
GNP per capita average annual growth rate (%)	1996–1997	2.5	Word bank
Human Development Index rank (HDI)	2000	155	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	33	UNESCO
Adult male literacy rate	1995	43	UNESCO
Adult female literacy rate	1995	23	UNESCO
Male secondary school enrolment ratio	1996	19.7	UNESCO
Female secondary school enrolment ratio	1996	11.9	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	39	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	13	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1,200	WHO
Life expectancy at birth	1998	64	UNPOP
Total fertility rate	1998	4.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	60	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	13	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	47	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	65	UNICEF

References

(1) Diop, I., Bollinger, L., and Stover, J. *The Economic Impact of AIDS in Senegal*. The Policy Project, Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities. 1999.

(2) The World Bank. HIV/AIDS: its impact on development. 2000.

(3) UNICEF. *The Progress of Nations*. Background paper. New York, UNICEF, 2000.

Seychelles

HIV/AIDS epidemiological summary

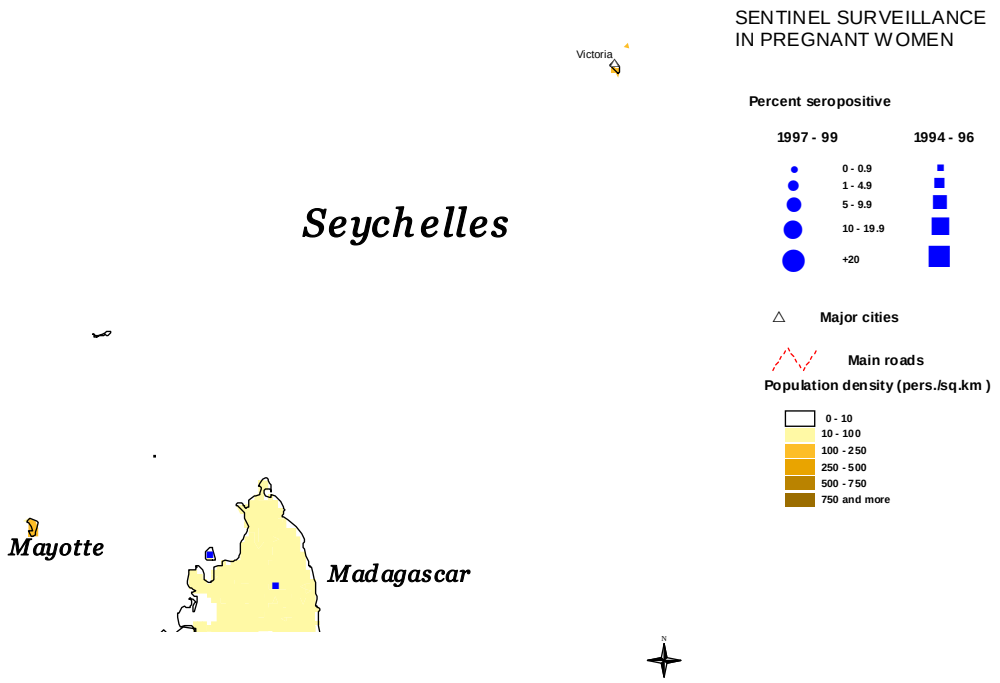
Very little information is available on the HIV prevalence in the Seychelles. In 1995, STI clinic patients had a prevalence of almost 2%. No information is available for antenatal clinic attendees.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
-	-	-	-	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic impact of HIV/AIDS

No data on the economic impact of HIV/AIDS on Seychelles were found in the literature review. However, if the epidemic develops at the same pace here as it has in many African nations, the impact will be felt in most sectors. In households and in the agricultural sector, illness and death may lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, detailed studies are required for an understanding of the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity in teaching, with many pupils losing or having a change in their teachers. Studies are required in order for us to understand how the epidemic is impacting on demand for education and health services as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Summary of the economic impact of HIV/AIDS

Not available

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Demand: Not available

Supply: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: WHO recently sent a consultant to assist the government prepare a draft for policy formulation.

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: No multisectoral policy so far.

Source: UNAIDS

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: NSP will be formulated after the adoption of the policy document

Source: UNAIDS

Date: July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements:

Source: UNAIDS

Date: July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	77	UNPOP
Population aged 15–49 (thousands)	-	-	UNPOP
Annual population growth (%)	1990–1998	1.0	UNPOP
% of population urbanized	1998	56	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.3	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1998	6420	UNDP
GNP per capita average annual growth rate (%)	1990-1998	1.4	UNDP
Human Development Index rank (HDI)	2000	53	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	86	UNESCO
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	-	-	-
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	21	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	7	UNPOP
Maternal mortality rate (per 100 000 live births)	-	-	-
Life expectancy at birth	1998	71	UNPOP
Total fertility rate	1998	2.1	UNPOP
Infant mortality rate (per 1000 live births)	1999	14	UNICEF/UNPOP
Contraceptive prevalence rate (%)	-	-	-
% of births attended by trained health personnel	1990–1999	99	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	99	UNICEF

References

Sierra Leone

HIV/AIDS epidemiological summary

Scant information on HIV prevalence is available for Sierra Leone. In an unspecified region, 1% of antenatal clinic women tested positive for HIV-1 and/or HIV-2 in 1990. Data were not available for the individual virus types. In 1992, 2% of antenatal clinic women, again in an unspecified region, tested positive for HIV-1.

A 1995 sero-survey conducted among sex workers in Freetown found that 27% tested positive for HIV-1.

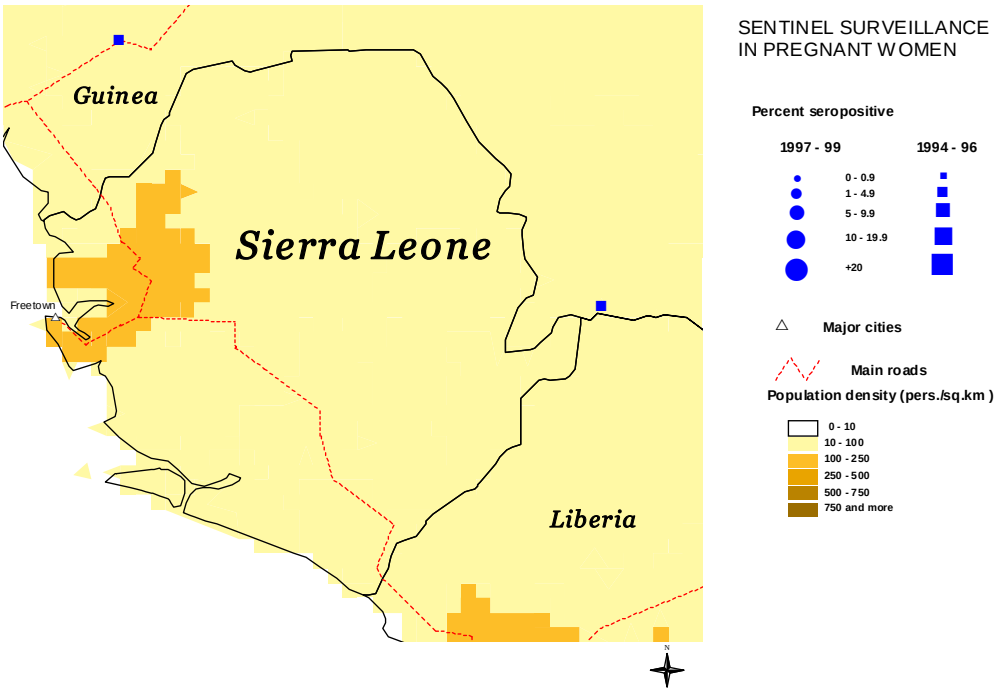
HIV prevalence among STI clinic patients tested in Freetown was about 3% between 1988 and 1992.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	68 000	65 000	2.99	36 000	3300

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	56 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	8200	UNAIDS/WHO, June 2000

Behavioural indicators	Most recent year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1992	2	2	2



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of AIDS in Sierra Leone were found. However, a modelling exercise carried out for the World Bank calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 9 million and US $ 14 million. This represents a per capita cost of around US$ 2–US$ 3 and approximately 1.8% of GDP. In the education sector, the current primary school enrolment is 44%. A model developed by UNAIDS and UNICEF shows how increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. This discontinuity, along with increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in this area, reducing enrolment and, hence, literacy rates. The potential impact on other sectors, including agriculture, households and firms, shown in other African nations to increase costs and expenditure, reduce savings and shift productivity patterns due to labour losses, needs to be carefully monitored in future studies to ensure an appropriate policy response.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 420 000 primary school students, 1900 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Demand: Not available

Supply: Not available

Resource gap: Annual costs of scaling-up HIV/AIDS programmes is estimated to be from US$ 9 million to US$ 14 million (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: A national HIV/AIDS policy document is being prepared by the National AIDS Control Programme.

Source: National AIDS Control Programme

Date: 17 July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: Sectoral HIV/AIDS policy documents are being prepared by the National AIDS Control Programme.

Source: National AIDS Control Programme

Date: 17 July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: National AIDS Control Programme

Date: 17 July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A National AIDS Co-ordinating Committee, reporting to the Ministry of Health. There is a clear need to revive it. Ad hoc inter-ministerial and parliamentary work on HIV/AIDS.

Source: National AIDS Control Programme

Date: 17 July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: National strategic planning has started. Preparatory seminars have been organized.

Source: National AIDS Control Programme

Date: 17 July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	NA

Comments/Key elements:

Source: National AIDS Control Programme

Date: 17 July 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	NA

Comments/Key elements:

Source: National AIDS Control Programme

Date: 17 July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	4717	UNPOP
Population aged 15–49 (thousands)	1999	2164	UNPOP
Annual population growth (%)	1990–1998	1.7	UNPOP
% of population urbanized	1998	34	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.2	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	160	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-20.6	World Bank
Human Development Index rank (HDI)	2000	174	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	31	UNESCO
Adult male literacy rate	1995	45	UNESCO
Adult female literacy rate	1995	18	UNESCO
Male secondary school enrolment ratio	1996	21.0	UNESCO
Female secondary school enrolment ratio	1996	12.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	45	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	24	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1800	WHO
Life expectancy at birth	1998	38	UNPOP
Total fertility rate	1998	6.0	UNPOP
Infant mortality rate (per 1000 live births)	1999	161	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	4	UNICEF/UNPOP
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized (DPT)	1995–1998	56	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Somalia

HIV/AIDS epidemiological summary

The only information on HIV prevalence information among antenatal clinic attendees from Somalia since 1985 are two studies conducted in Hargeysa and Boosaso in 1997. Among the antenatal clinic women tested, 2% were HIV-positive.

Information on HIV prevalence among sex workers is available from the mid-1980s until 1990. In Mogadishu, the major urban area, no evidence of HIV infection was found among sex workers tested in 1985–86 or in 1987. In 1988–89, 0.5% of sex workers tested were HIV-positive. The rate increased to 2% in 1990. HIV prevalence increased among sex workers in Kismaayo and Marka from no evidence of HIV infection in 1989 to 4% in 1990. No recent information is available on this group.

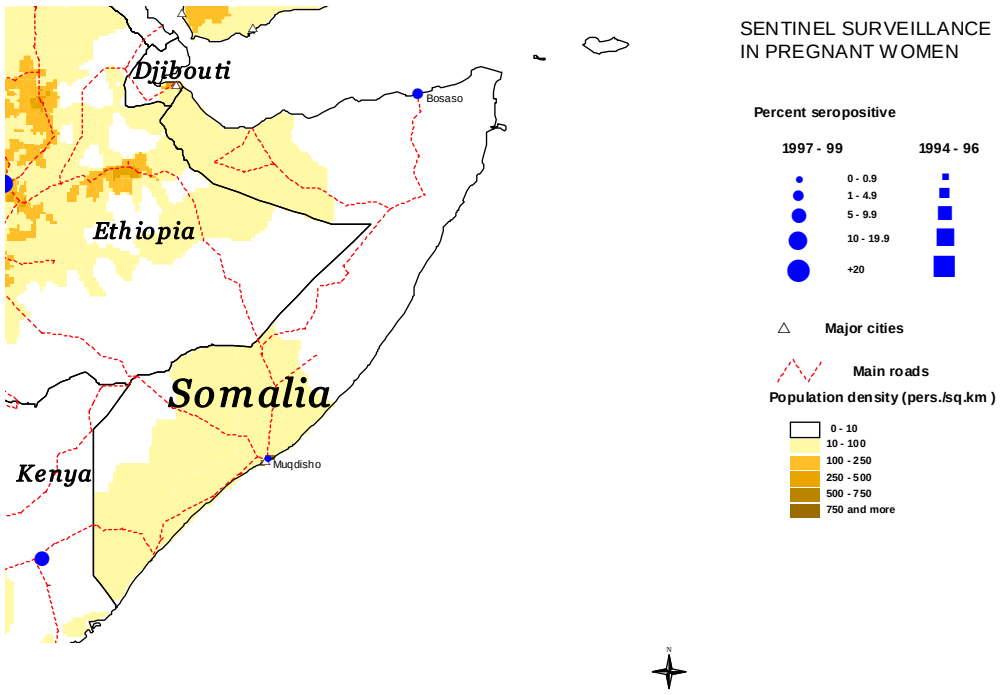
Among STI clinic patients tested in Mogadishu between 1986 and 1990, there was no evidence of HIV infection.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
-	-	-	-	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	-	-	-	-



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No data on the economic impact of AIDS in Somalia were found in the literature review carried out. In the education sector, increasing numbers of orphans and children's growing responsibilities, as a consequence of AIDS in the household, could result in lower school enrolment and, hence, literacy rates. Likewise, the potential impact on other sectors, shown in other African nations as increasing costs and expenditure, reduced savings and shifting productivity patterns due to labour losses, needs to be carefully considered in future studies. With this information, appropriate policy responses can be developed and the impact of the epidemic therefore minimized.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements: In collaboration with the UN system and international NGOs, the Somali Aid Coordination Board is currently trying to develop a working policy on HIV/AIDS.

Source: Somalia Aid Coordination Board

Date: July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: Somalia AID Coordination Board

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements: Information not available

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key element:

Source: UNAIDS Kenya

Date: July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: NA

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: NA

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	9672	UNPOP
Population aged 15–49 (thousands)	1999	4255	UNPOP
Annual population growth (%)	1990–1998	2.2	UNPOP
% of population urbanized	1998	26	UNPOP
Average annual growth rate of urban population (%)	1990–1998	3.0	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	-	-	-
GNP per capita average annual growth rate (%)	-	-	-
Human Development Index rank (HDI)	-	-	-
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	-	-	-
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	1996	6.6	UNESCO
Female secondary school enrolment ratio	1996	3.5	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	52	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	17	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1600	WHO
Life expectancy at birth	1998	47	UNPOP
Total fertility rate	1998	7.2	UNPOP
Infant mortality rate (per 1000 live births)	1999	114	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	1	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	2	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	24	UNICEF

References

South Africa

HIV/AIDS epidemiological summary

National sentinel surveillance surveys of antenatal clinic attendees have been conducted in South Africa since 1990. HIV information is available by state. In KwaZulu-Natal, Western Cape, Eastern Cape and Gauteng provinces, where the major urban areas of Durban, Cape Town, Port Elizabeth, Johannesburg and Pretoria are located, HIV prevalence among antenatal clinic attendees tested increased from less than 1% in 1990 to a median of 19% in 1998. In 1998, HIV prevalence ranged from 5% to 33%. Age data are available for the years 1991-1998. A province breakdown of age data is available for the years 1993 to 1997. HIV prevalence among antenatal clinic attendees less than 20 years of age increased from 2% in 1991 to 20% in 1996. In 1997, 10% of antenatal clinic women less than 15 years of age tested HIV-positive. Peak HIV infection occurred among antenatal clinic attendees 20-24 years of age. In Free State, Northern Cape, Mpumalanga, Northern and North-West provinces, HIV prevalence among antenatal clinic attendees tested increased from less than 1% in 1990 to 21% in 1998. In 1998, HIV prevalence ranged from 10% to 30%. Age detail is available for the years 1991-1997. HIV prevalence among antenatal clinic attendees less than 20 years of age increased from less than 1% to 14%. Peak HIV prevalence occurred among women aged 20-29 years of age.

HIV prevalence among sex workers tested in KwaZulu-Natal increased from 50% in 1997 to 61% in 1998.

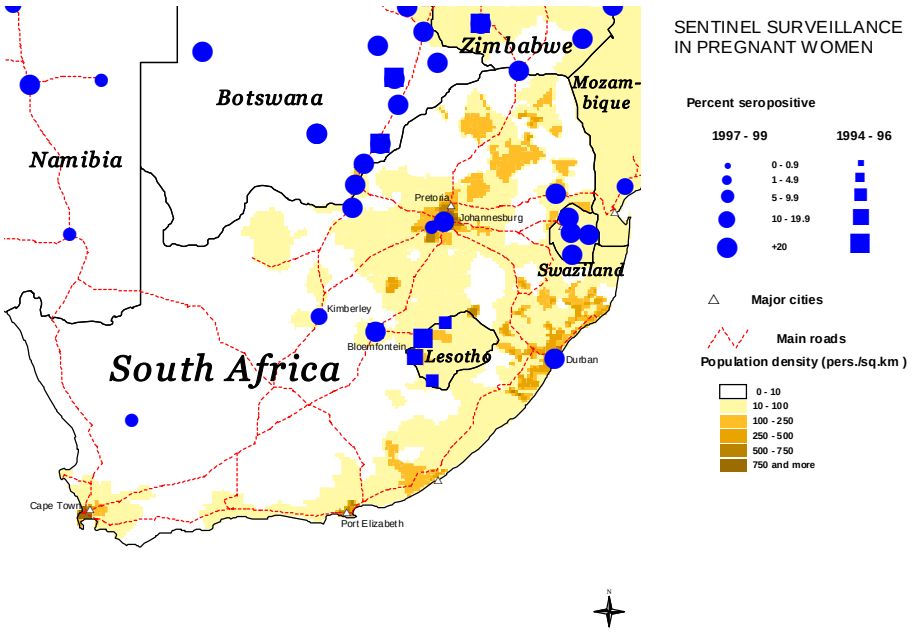
Information on HIV prevalence among STI clinic patients has been available from Johannesburg since 1988. Among male STI clinic patients, HIV prevalence increased from 1% in 1988 to 19% in 1994. Among females, HIV prevalence increased from 2% in 1988 to 25% in 1994.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	4 200 000	4 100 000	19.94	2 300 000	95 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	420 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	250 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	19.2	5.2	32.5



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in South Africa are limited. Most studies concentrate on the economy as a whole and the health and business sectors, where, to date, the impact of AIDS is most visible. The rising costs to these sectors are evident. In the area of education, a UNAIDS/UNICEF model shows that increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. In addition, anecdotal evidence suggests that children have difficulty attending school due to costs and increased responsibilities. Further studies are required to assess the real impact in this sector, as well as in agriculture and households, and to ensure that policy responses to the epidemic are shaped appropriately.

Macroeconomic impact

The impact of AIDS on GDP has been modelled in two recent studies: real growth in GDP is forecast to be 0.3% lower than without AIDS in 2005 (1); the decline in the annual GDP growth rate per capita by 2010 is estimated to be 1% (2).

A 1998 model of human development projected the ratio of the Human Development Index (HDI) with AIDS to that without AIDS to be 0.85 by 2010 (3).

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

A 1997 study of expected impact of AIDS showed that the total costs of benefits would rise from 7% of salaries in 1995 to 19% by 2005 (4). Metropolitan Life Insurance Co. estimates that the remuneration costs paid by firms will increase by about 15% as a result of AIDS (5). In 1997, the total costs of AIDS to the mining industry were estimated at 114 million R for 1995 and projected to reach 1509 million R in 2010 (4).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 8 million primary school students, 100 000 would have lost a teacher to AIDS in 1999 (6).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: The percentage of adult hospital beds occupied due to AIDS ranges from 26% to 70% for adults (7) and from 26% to 30% for children (8).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 112 million and US$ 180 million (9).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: The principles for HIV/AIDS and STI prevention, treatment and care efforts for South Africa were adopted in the National AIDS Plan for South Africa (1994-1995) and in the Department of Health White Paper for the Transformation of the Health Sector in South Africa (1997).

Source: HIV/AIDS/STD Strategic Plan for South Africa 2000–2005

Date: February 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others, Prisons & Immigration		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: A national legislation on testing, treatment of opportunistic diseases and good practice in the workplace are currently being finalized.

Source: UNAIDS South Africa

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

Institutional and management structures have been put in place at different levels to plan and manage the response to the epidemic:

- The National AIDS Council: policy decision-making, advise government on all matters of policy relating to HIV/AIDS; chaired by the Deputy President and consisting of 15 government representatives and 16 civil society representatives;
- Technical Task Teams on 1) prevention; 2) care and support; 3) IEC and social mobilization; 4) research, monitoring, surveillance and evaluation; and 5) legal issues and human rights;
- Inter-Ministerial Committee on AIDS: chaired by the Deputy President, and composed of all Ministers and Deputy Ministers, it provides guidance to the National AIDS Programme;
- Interdepartmental Committee on AIDS: includes representatives of all government departments who coordinate HIV/AIDS activities; goals are to facilitate the development of HIV/AIDS workplace policies and ensure that the government allocates financial resources to HIV/AIDS;
- MINMEC: Members of the Executive Council (MECs) of Provincial Government and the national Ministry of Health meet every six weeks to approve national policies and guidelines;
- Provincial Health Restructuring Committee (PHRC): provincial heads of Health discuss strategic issues of national and provincial importance;
- Director Generals' Forum: regular meeting of director generals from all National Government Departments.
- National AIDS Unit located in the Department of Health prepares briefing documents for the national forums and provides information to decision-makers.

Source: UNAIDS

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: The HIV/AIDS/STD Strategic Plan for South Africa 2000–2005 has been formulated. The plan will be officially launched in July 2000.

Source: UNAIDS South Africa

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Four priority areas identified in the HIV/AIDS/STD Strategic Plan for South Africa 2000–2005 for action:

1) Prevention (promote safe and healthy sexual behaviour, improve management/control of STI, reduce MTCT, blood transfusion, post-exposure services, improve access to voluntary testing and counselling);
2) Treatment care and support (in health facilities, in communities, for children/orphans);
3) Research, monitoring and surveillance (AIDS vaccine development, investigate treatment and care options, policy research, regular surveillance);
4) Human rights (create appropriate social, legal and policy environment).

Source: The HIV/AIDS/STD Strategic Plan for South Africa 2000–2005 (February 2000)/UNAIDS South Africa

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: An operational plan covering the first three years of the HIV/AIDS/STD Strategic Plan for South Africa 2000–2005, has been costed.

Source: UNAIDS South Africa

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	39 900	UNPOP
Population aged 15-49 (thousands)	1999	20 962	UNPOP
Annual population growth (%)	1990–1998	1.8	UNPOP
% of population urbanized	1998	49	UNPOP
Average annual growth rate of urban population (%)	1990–1998	1.7	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	3210	World Bank
GNP per capita average annual growth rate (%)	1996–1997	-0.4	World Bank
Human Development Index rank (HDI)	2000	103	UNDP
% population economically active	-	-	-
Unemployment rate	1997	5.1	ILO
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	82	UNESCO
Adult male literacy rate	1995	82	UNESCO
Adult female literacy rate	1995	82	UNESCO
Male secondary school enrolment ratio	1996	76.5	UNESCO
Female secondary school enrolment ratio	1996	91.4	UNESCO

Health indicators	Year	Estimate	Source
Crude birth rate (births per 1000 pop.)	1999	26	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	14	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	230	WHO
Life expectancy at birth	1998	54	UNPOP
Total fertility rate	1998	3.2	UNPOP
Infant mortality rate (per 1000 live births)	1999	60	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	50	UNICEF/UNPOP
% of births attended by trained health personnel	1990–199	82	UNICEF
% of one-year-old children fully immunized-DPT	1995–1998	73	UNICEF

References

(1) ING Barings. *Economic Impact of AIDS in South Africa: a dark cloud on the horizon*. ING Barings, 4-1-2000.

(2) Bonnel, R. *What Makes an Economy HIV-Resistant? D*raft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(3) UNAIDS and UNDP. *HIV/AIDS and Human Development in South Africa*. South Africa, UNDP, 1998.

(4) AIDS toll on regional economies. *Southern African Economist* 1997 Apr 15.

(5) Moore, D. The AIDS threat and the private sector. *AIDS Analysis Africa* 1999; **9**(6):1-2.

(6) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(7) Kinghorn, A. and Steinberg, M. *HIV/AIDS in South Africa: The Impacts and the Priorities*. South Africa, Department for International Development in Southern Africa and the Department of Health. 1999.

(8) Taylor, V. *HIV/AIDS and Human Development in South Africa*. UNDP/UNAIDS. 1998.

(9) World Bank. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Sudan

HIV/AIDS epidemiological summary

Information on HIV prevalence among antenatal clinic women has only recently become available. A study conducted in Khartoum in 1996 found that 5% of antenatal clinic women tested were HIV-positive. However, in 1998, less than 1% of antenatal clinic women tested were HIV-positive. Outside Khartoum, a study conducted in Juba in 1995 found that 3% of antenatal clinic women tested were HIV-positive. In 1998, 4% of antenatal clinic women in Juba and El Gedarif tested HIV-positive.

There is no information on HIV prevalence in sex workers.

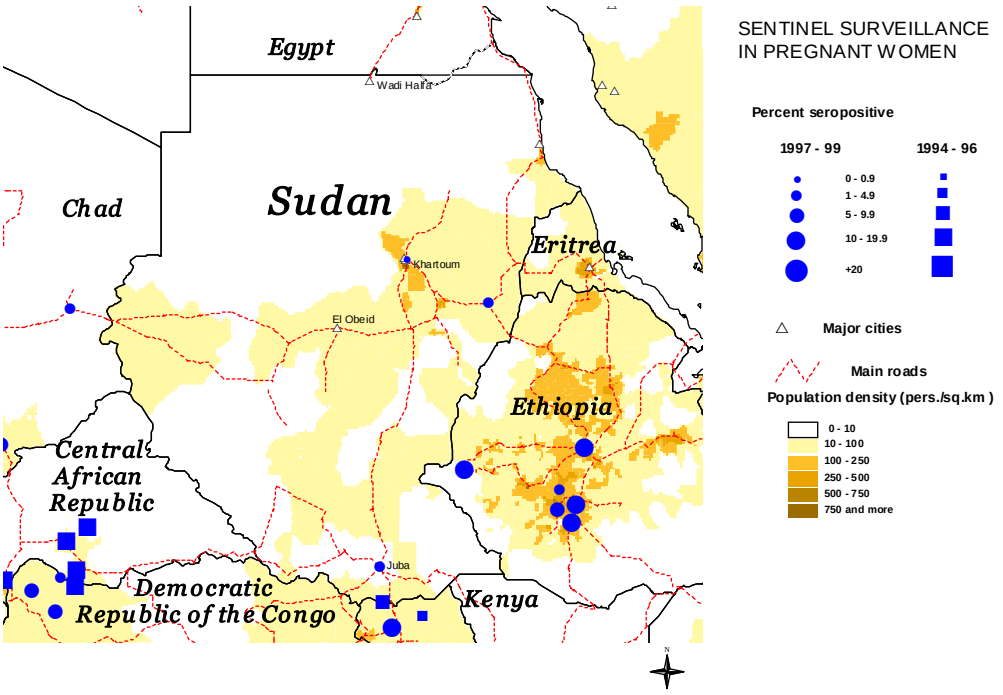
In Juba, HIV prevalence among STI clinic patients tested ranged from 2% to 7% between 1991 and 1994. In 1997, 3% of STI clinic patients tested in an unspecified site were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	140 000	0.99	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	1995	15–49	3.0	1.0

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	0.5	0.5	0.5



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Sudan were found. However, as with many sub-Saharan African nations, as prevalence rises, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, more detailed studies are required in order for us to understand the full impact. In education, an international model developed by UNAIDS and UNICEF shows how increasing mortality due to AIDS leads to discontinuity, with many pupils losing or having a change in their teachers. Data are also required for an understanding of how the epidemic is impacting on supply and demand in all these sectors.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Demand: Not available

Supply: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
	X

Comments/Key elements:

Source: CTG (Chair, Theme Group)

Date: 22 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: CTG

Date: 22 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: CTG

Date: 22 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: The national response has just begun to develop. The Sudan National AIDS Programme falls within the responsibility of the Federal Ministry of Health. There is a plan to form an inter-ministerial body. The CTG is playing a major role in initiating high-level involvement in the HIV/AIDS programme.

Source: CTG

Date: 22 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: The SPP has been initiated by SNAP in collaboration with CTG. The SPP is expected to be ready by the middle of 2001.

Source: CTG

Date: 22 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	X

Comments/Key elements: Being worked out.

Source: CTG

Date: 22 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: UNAIDS Geneva provided US$ 147 000 through a cost-sharing agreement with UNDP.

Source: CTG

Date: 22 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	26 883	UNPOP
Population aged 15–49 (thousands)	1999	14 199	UNPOP
Annual population growth (%)	1990–1998	2.0	UNPOP
% of population urbanized	1998	33	UNPOP
Average annual growth rate of urban population (%)	1990–1998	4.3	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	290	World Bank
GNP per capita average annual growth rate (%)	1996–1997	4.2	World Bank
Human Development Index rank (HDI)	2000	143	UNDP
% population economically active	1993	33.7	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	46	UNESCO
Adult male literacy rate	1995	58	UNESCO
Adult female literacy rate	1995	35	UNESCO
Male secondary school enrolment ratio	1996	21.2	UNESCO
Female secondary school enrolment ratio	1996	19.1	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	33	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	11	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	660	WHO
Life expectancy at birth	1998	55	UNPOP
Total fertility rate	1998	4.6	UNPOP
Infant mortality rate (per 1000 live births)	1999	68	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	8	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	69	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	72	UNICEF

References

Swaziland

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from sentinel surveillance in Swaziland since 1992. Only the national-level totals were available for the years 1993 and 1995. HIV information for Hhohho region, the major urban area, is available for 1992, 1994, 1996, and 1998. In 1992, 4% of antenatal clinic women tested in Hhohho were HIV-positive, as were 4% of the women tested in Lubombo, Manzini, and Shiselweni. By 1998, 30% of antenatal women tested in Hhohho and 32%, tested outside, were HIV-positive. In Hhohho, in 1998, 23% of 15–19-year-olds tested HIV-positive and 39% of women 20–24 years of age tested HIV-positive. Outside Hhohho, in 1998, 24% of antenatal clinic attendees less than 20 years of age were HIV-positive and 37% of attendees 20-24 years of age tested HIV-positive.

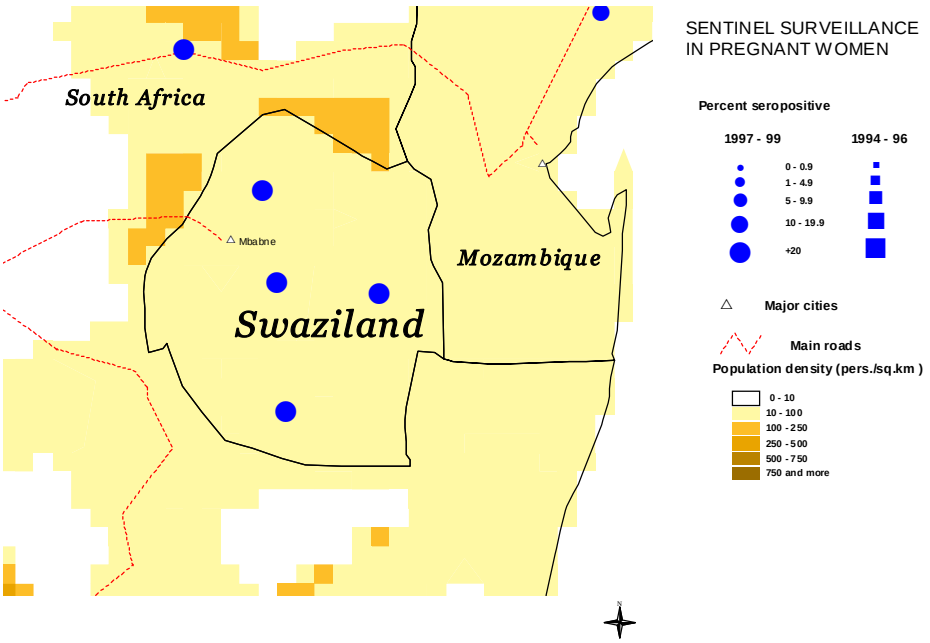
There is no information available on HIV prevalence among sex workers. HIV sentinel surveillance information has been available for male STI clinic patients since 1992. In Hhohho, HIV prevalence among male STI clinic patients tested increased from 10% in 1992 to 51% in 1998. Outside of Hhohho, HIV prevalence information is available from Lubombo, Manzini and Shiselweni. HIV prevalence among male STI clinic patients increased from 12% in 1992 to 47% in 1998. Among female STI clinic patients, HIV prevalence had reached 47% of women tested in Hhohho in 1998 and 50% of women tested outside of Hhohho.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	130 000	120 000	25.25	67 000	3800

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	12 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	7100	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over 12-month period (%)	1991	14–49	19.2	6.1

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	30.3	30.3	30.3



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS in Swaziland are limited. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is substantial. No data exist on the impact at the household level or on agriculture. However, it is likely that, as prevalence rises, morbidity and mortality, shifting production patterns and loss of labour will result in increased costs and reduced productivity. No data were found on the impact on businesses but it is likely that firms are already facing rising costs in order to cover employees' AIDS-related medical and funeral expenses. In education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS lead to discontinuity, with many pupils losing or having a change in their teachers. The health sector is having to cope with hospitals where over 50% of beds are occupied by patients with AIDS-related illness, and with increasing AIDS-related mortality among its workers. In addition, there are still extensive investments required to scale-up AIDS programmes: equivalent to US$ 5-US$ 6.5 per capita and 0.5% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 1.2% by 2010 (1).

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 210 000 primary school students, 3600 would have lost a teacher to AIDS in 1999 (3). Due to AIDS deaths and sickness, the Government of Swaziland estimates that 2.21 times as many teachers will have to be trained to keep services at 1997 levels (4).

Demand: In 1994, it was estimated that there was a 0.5% reduction in 6-year-olds entering school as a result of HIV/AIDS; this was projected to increase to 5% and 16.6% in 2000 and 2006 respectively (2).

Economic impact on the health sector

Supply: Mortality of health care staff was estimated to rise by 2% over a 3-year period from 1994, due to AIDS (2).

Demand: In 1994, it was estimated that over 50% of hospital beds would be occupied by AIDS patients by 1998; AIDS/HIV-related illness accounted for 13% of MOH budget in 1994 (2).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is calculated to be US$ 4.8 million – US$ 6.6 million (5).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Being reviewed. HIV/AIDS Crisis Management and Technical Committee

Source: UNAIDS Swaziland

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health	X	
Military	X	
Workplace	X	
Sports		X
Others		X

Comments/Key elements: Private sectors have HIV/AIDS workplace policies

Source: UNAIDS Swaziland

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Swaziland

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A Cabinet Committee on HIV/AIDS chaired by the Deputy Prime Minister was established in May 1999. In addition, a Multi-sectoral HIV/AIDS Crisis Management and Technical Committee has been set up to coordinate the national response.

Source: UNAIDS Swaziland

Date: May 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: To have been finalized by end of June 2000.

Source: UNAIDS Swaziland

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: The National Strategic Plan identifies the following three components: Risk Reduction, Response Management and Impact Mitigation, with priority areas clearly identified under each component.

Source: UNAIDS Swaziland

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Proposed Special Fund for HIV/AIDS. Increased budget for both Crisis Management and Technical Committee and Swaziland National AIDS Programme in Ministry of Health & Social Welfare.

Source: UNAIDS Swaziland

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	960	UNPOP
Population aged 15-49 (thousands)	1999	468	UNPOP
Annual population growth (%)	1990–1998	2.9	UNPOP
% of population urbanized	1998	32	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.6	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1998	1400	UNDP
GNP per capita average annual growth rate (%)	1990-1998	-0.2	UNDP
Human Development Index rank (HDI)	2000	112	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	77	UNESCO
Adult male literacy rate	1995	78	UNESCO
Adult female literacy rate	1995	76	UNESCO
Male secondary school enrolment ratio	1996	52.4	UNESCO
Female secondary school enrolment ratio	1996	51.7	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	37	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	9	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	560	WHO
Life expectancy at birth	1998	60	UNPOP
Total fertility rate	1998	4.7	UNPOP
Infant mortality rate (per 1000 live births)	1999	62	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	21	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	56	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	76	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Whiteside, A. and Wood, G. *The socio-economic impact of AIDS in Swaziland*. Mbabane, Government of Swaziland, 1994.

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) Ministry of Education. *Impact assessment of HIV/AIDS on the education sector*. Draft. Mbabane, Swaziland, Ministry of Education, 2000.

(3) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

Togo

HIV/AIDS epidemiological summary

HIV surveillance information on antenatal clinic women has been available from Togo since 1991. Lomé is considered the major urban area in Togo. In 1996 and 1997, sentinel surveillance among antenatal clinic women tested in Lomé reported HIV prevalence ranging from 7% to 8%. In 1992, 16.5% of antenatal clinic women tested in Lomé were HIV-1- and/or HIV-2-positive. Data for the individual viruses were not available. Outside Lomé, HIV prevalence information is available from Dapaong for the years 1991-1993. In 1991, 1% of the antenatal clinic women tested HIV-1- and/or HIV-2-positive. From 1992 to 1993 in Dapaong, HIV-1 prevalence increased from nearly 2% to 3% of antenatal clinic women tested. In 1993, nearly 2% of the women less than 20 years of age in Dapaong were HIV-1-infected. Between 1994 and 1997, HIV prevalence among antenatal clinic women tested at sentinel surveillance sites was 5%. HIV prevalence ranged from 3% to 8% of women tested in 1997.

One study of sex workers conducted in Lomé in 1992 showed that nearly 80% of the women tested HIV-1- and/or HIV-2-positive. Prevalence by virus type was not available, nor was any other information on prevalence rates among sex workers.

In 1992, 45% of STI clinic patients tested in Lomé were HIV-positive. In Dapaong, HIV prevalence among STI clinic patients tested ranged from 7% to 10% between 1991 and 1993.

A study of truck drivers in Lomé conducted in 1992 reported that 33% tested were HIV-1- and/or HIV-2-positive.

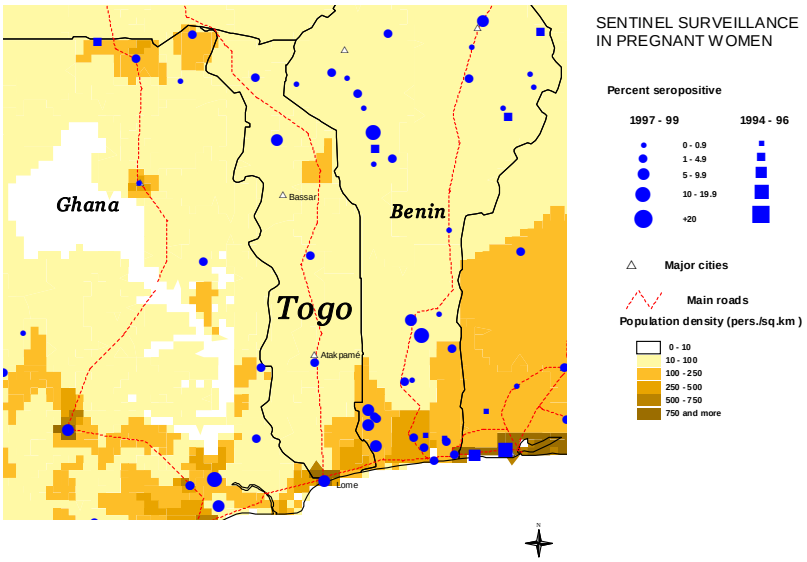
In 1995 and 1996, 2% of army recruits tested HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	130 000	120 000	5.98	66 000	6300

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	95 000	UNAIDS/WHO, JUNE 2000
Estimated AIDS deaths	1999	14 000	UNAIDS/WHO, JUNE 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1998	15+	35.2	-
Reported non-regular sexual partnership over a 12-month period (%)	1998	15+	18.4	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	6.8	6.8	6.8



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

No empirical data on the economic impact of HIV/AIDS on Togo were found in the literature review. Only international studies using models to explore the effect of AIDS on the education and health systems provided any information on the potential impact in the country. However, as with many sub-Saharan African nations, the impact will be felt in each of the sectors identified here. In households and in the agricultural sector, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. In the area of businesses, more detailed studies are required to understand the full impact. In education, a model developed by UNAIDS and UNICEF in 2000 shows how increasing mortality rates due to AIDS lead to discontinuity, with many pupils losing or having a change in their teachers. In the health sector, there are still extensive investments required to scale-up AIDS programmes equivalent to US$ 2–US$ 3 per capita and 0.9% of GDP. Data are also required in order for us to understand how the epidemic is impacting on demand for education and health as well as how supply in the health sector might be affected by rising infection rates in health care workers.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 830 000 primary school students, 7300 would have lost a teacher to AIDS in 1999 (1).

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: The annual costs of scaling-up HIV/AIDS programmes is estimated to be between US$ 10 million and US$ 14 million. (2).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: MTPII 1995 2000

Source: UNAIDS

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements: No specific policy but all sectors are considered in MTP II

Source: UNAIDS

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements: No specific legislation, but national recommendation.

Source: UNAIDS

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
	X

Comments/Key elements: However, the proposal has been made to locate a coordinating body at high level.

Source: UNAIDS

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
	X

Comments/Key elements: Under preparation, situation analysis being conducted.

Source: UNAIDS

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
	NA

Comments/Key elements: National strategic plan under preparation.

Source: UNAIDS

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	NA

Comments/Key elements: National strategic plan under preparation.

Source: UNAIDS

Date: June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	4512	UNPOP
Population aged 15–49 (thousands)	1999	2008	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	31	UNPOP
Average annual growth rate of urban population (%)	1999	4.1	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1997	340	World Bank
GNP per capita average annual growth rate (%)	1996–1997	2.0	World Bank
Human Development Index rank (HDI)	2000	145	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	52	UNESCO
Adult male literacy rate	1995	67	UNESCO
Adult female literacy rate	1995	37	UNESCO
Male secondary school enrolment ratio	1996	39.7	UNESCO
Female secondary school enrolment ratio	1996	14.4	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	41	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	15	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	640	WHO
Life expectancy at birth	1998	49	UNPOP
Total fertility rate	1998	6.0	UNPOP
Infant mortality rate (per 1000 live births)	1999	82	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	24	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	51	UNICEF
% of one-year-old children fully immunized –(DPT)	1995–1998	37	UNICEF

References

(1) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(2) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level in Sub-Saharan Africa*. Draft report, 2000.

Tunisia

HIV/AIDS epidemiological summary

One study conducted in 1991 among antenatal clinic women in Tunis found no evidence of HIV infection. A study conducted in 1999 in an unspecified area found no evidence of infection among antenatal clinic women tested.

HIV testing among sex workers found that less than 1% of women tested were HIV-positive through most of the 1990s, with no evidence of infection among women tested in 1998 and 1999.

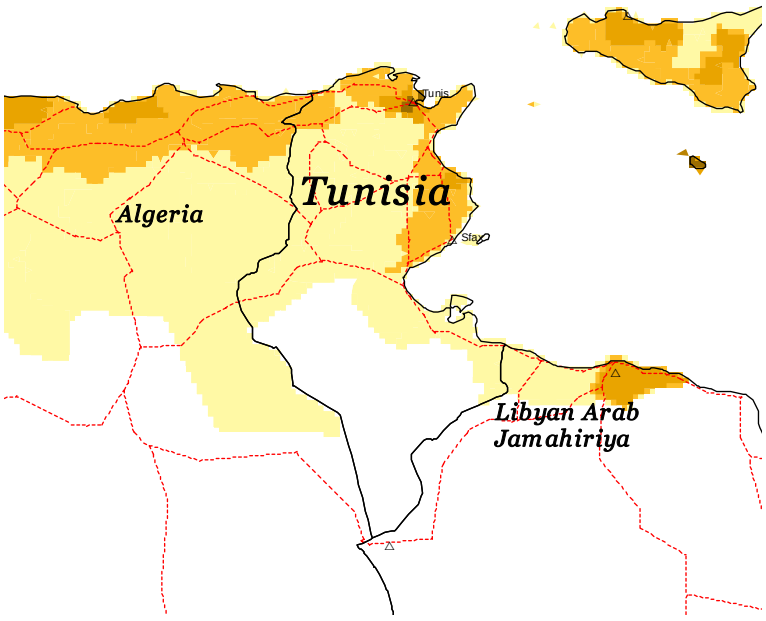
One per cent of IV drug users tested between 1993 and 1996 were HIV-positive. In 1997, 0.3% of IV drug users tested were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	-	2200	0.04	-	-

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	-	-	-
Estimated AIDS deaths	-	-	-

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1991	0.0	0.0	0.0



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

As with many of the countries of Northern Africa, no data on the economic impact of AIDS in Tunisia were found. With the prevalence of AIDS in these areas at a low level, the impact is most felt in the health sector and at the household level. Data are required in order for us to understand the current level of demand on the health sector and the future costs. In households, illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns. Again, studies are required in order for us to understand the nature of the effect of the epidemic. Information in these areas can help shape policy responses appropriately so that the extent of the epidemic's impact is minimized.

Macroeconomic impact

Not available

Economic impact of HIV/AIDS on households

Not available

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: Not available

Demand: Not available

Economic impact on the health sector

Supply: Not available

Demand: Not available

Resource gap: Not available

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education		
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No

Comments/Key elements:

Source: Not available

Date: Not available

Organizational structure

Existence of high-level structure in support of the national response

Not available

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Not available

Source: Not available

Date: Not available

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	9460	UNPOP
Population aged 15–49 (thousands)	1999	5170	UNPOP
Annual population growth (%)	1990–1998	1.7	UNPOP
% of population urbanized	1998	63	UNPOP
Average annual growth rate of urban population (%)	1990–1998	2.7	UNPOP

Economic Indicators	Year	Estimate	Source
GNP per capita (US$)	1998	2060	UNDP
GNP per capita average annual growth rate (%)	1990–1998	2.7	UNDP
Human Development Index rank (HDI)	2000	101	UNDP
% population economically active	1989	31.6	ILO
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	67	UNESCO
Adult male literacy rate	1995	79	UNESCO
Adult female literacy rate	1995	55	UNESCO
Male secondary school enrolment ratio	1996	66.7	UNESCO
Female secondary school enrolment ratio	1996	64.5	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	20	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	7	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	170	WHO
Life expectancy at birth	1998	70	UNPOP
Total fertility rate	1998	2.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	29	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	60	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	81	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	96	UNICEF

References

Uganda

HIV/AIDS epidemiological summary

Uganda has been cited as the success story in sub-Saharan Africa in its efforts to reduce HIV prevalence levels.

Information on HIV prevalence among antenatal clinic attendees has been available from Uganda since the mid-1980s. In Kampala, the major urban area, HIV prevalence among antenatal clinic attendees tested increased from 11% in 1985 to 31% in 1990. Beginning in 1993, however, HIV prevalence among antenatal clinic attendees began to decline in Kampala, reaching 14% in 1998. HIV prevalence by age has been available since 1990. In 1991, 28% of antenatal clinic women who were less than 20 years of age tested HIV-positive. This rate dropped to 6% in 1998. Sentinel surveillance of antenatal clinic attendees outside Kampala began in 1989. Median HIV prevalence of antenatal clinic attendees outside Kampala has declined from 13% of antenatal clinic women attendees tested in 1992 to 8% in 1998. HIV prevalence information by age has been available from one or two sites over the years since 1990. In 1990, 21% of antenatal clinic women less than 20 years of age tested outside Kampala were HIV-positive. This rate dropped to 8% of antenatal clinic attendees less than 20 years of age tested in 1998.

In 1989, 42% of male STI clinic patients in Kampala tested HIV-positive. By 1992, HIV prevalence had increased to 46%. In 1998, 30% of male STI clinic patients tested were HIV-positive. In 1989, 62% of female STI clinic patients tested in Kampala were HIV-positive and, by 1997, HIV prevalence among female STI clinic patients tested had declined to 37%.

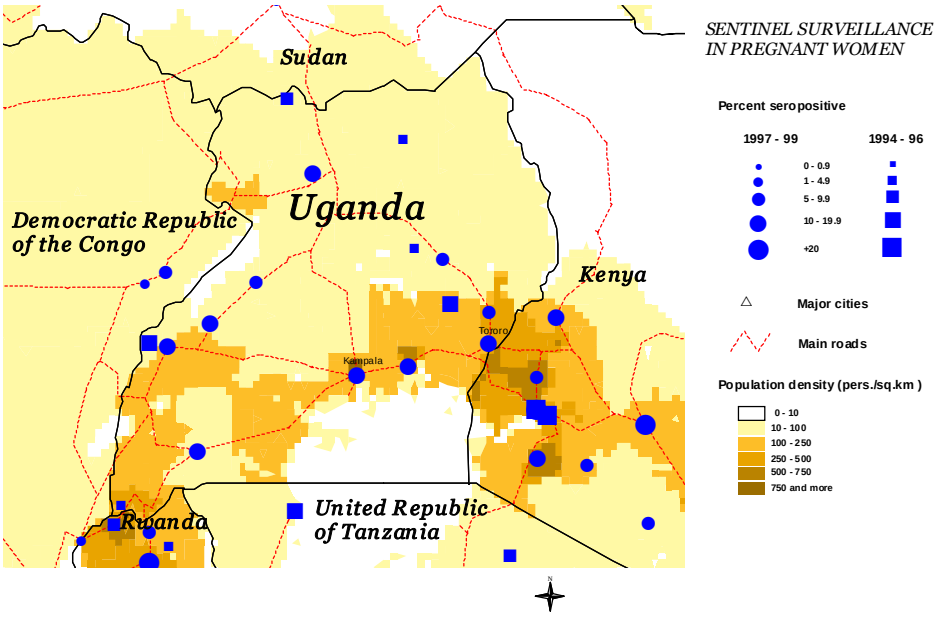
Among military recruits, however, HIV prevalence has increased; among those tested in Kampala, HIV prevalence increased from 16% in 1992 to 27% in 1996.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	820 000	770 000	8.30	420 000	53 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	1 700 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	110 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1995	Rural 15–49	16.0	18.0
		Urban 15–49	64.0	49.0
Reported non-regular sexual partnership over a 12-month period (%)	1995	Rural 15–49	14.0	3.6
		Urban 15–49	25.2	12.6

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	13.8	13.4	14.2



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact on Uganda are relatively extensive as compared with many other countries in sub-Saharan Africa. Preliminary results of a recently developed model on the macroeconomic impact of AIDS show that the impact is average compared with other countries of sub-Saharan Africa. Of the sectors explored here, the impact on households and agriculture shows increased expenditure and reduced time for agricultural labour as a result of illness. There is little work in the area of businesses and more detailed studies are required in order for us to understand the full impact on this sector. In the area of education, a model developed by UNAIDS and UNICEF shows how increasing mortality rates due to AIDS have led to discontinuity in teaching, with many pupils losing or having a change in their teachers. In addition, the reduction in probability of school enrolment for orphans suggests that increasing orphanhood due to AIDS is having an impact on literacy. The studies in health demonstrate that the health system is being stretched by the need to care for people with AIDS, and there is still a large gap in funding to meet the full needs of a scaled-up care and prevention programme, equivalent to US$ 3 to US$ 5 per capita and 1.8% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 0.8 % by 2010 (1).

Economic impact of HIV/AIDS on households

A survey in Rakai district in 1995 showed that, compared with an average monthly household income of US$ 18, AIDS-related expenditures were US$ 20 for a burial and US$ 40 for the medical costs of a terminal patient. In addition, 65% of the households in the survey had to sell property to cover the costs of AIDS care (2).

Economic impact of HIV/AIDS on agriculture

In a household in the mid-1990s, where the male head had died, the length of the average working day for household members was found to increase by two-to-four hours to make up for lost income (3).

Economic impact of HIV/AIDS on firms

Not available

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 5 million primary school students, 81 000 would have lost a teacher to AIDS in 1999 (4).

Demand: A household survey in Kampala in 1990 found that 47% of households with orphans did not have enough money to send children to school, compared with 10% in non-orphan households (5).

Economic impact on the health sector

Supply: Not available

Demand: Over 50% of patients admitted to Rubaga hospital, Kampala were HIV-positive in 1994 (6).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is between US$ 74 million and US$ 121 million (7).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: HIV/AIDS Policy since 1992.

Source: UAC

Date: 6 June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture	X	
Education	X	
Health	X	
Military	X	
Workplace	X	
Sports (with education)	X	
Others	X	

Comments/Key elements: Ministries of: Gender, Labour and Social Development, local government, public services, Presidency (information, Ethics)

Source: UAC

Date: 20 June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
X	

Comments/Key elements: Draft Health Services Act

Source: UAC

Date: 20 June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: Uganda AIDS Commission since 1990. Placed at Presidency level.

Source: UAC

Date: 20 June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: National Strategic Framework (NSF) revised and adopted in February 2000

Source: UAC

Date: 20 June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: A Scale-up Priority Action Plan has been drawn from the NSF and is being implemented.

Source: UAC

Date: 20 June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Rough costing of the NSF. More in-depth costing of the sector plans needs to be made.

Source: UAC

Date: 20 June 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	21 143	UNPOP
Population aged 15–49 (thousands)	1999	9206	UNPOP
Annual population growth (%)	1990–1998	2.8	UNPOP
% of population urbanized	1998	13	UNPOP
Average annual growth rate of urban population (%)	1990–1998	5.0	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	330	World Bank
GNP per capita average annual growth rate (%)	1996–1997	3.0	World Bank
Human Development Index rank (HDI)	2000	158	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	62	UNESCO
Adult male literacy rate	1995	74	UNESCO
Adult female literacy rate	1995	50	UNESCO
Male secondary school enrolment ratio	1996	14.8	UNESCO
Female secondary school enrolment ratio	1996	8.7	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	51	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	21	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	1200	WHO
Life expectancy at birth	1998	40	UNPOP
Total fertility rate	1998	7.1	UNPOP
Infant mortality rate (per 1000 live births)	1999	103	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	15	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	38	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	46	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Impact of AIDS on families in Rakai District. *Intl Conf AIDS*, 1996.

(3) Topouzis, D. *The socio-economic impact of HIV/AIDS on rural families with an emphasis on rural youth*. TCP/UGA/2556. Rome, FAO, 1994.

(4) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(5) Muller, O., Abba N. The impact of AIDS mortality on children's education in Kampala (Uganda). *AIDS Care* 1990; 2(1):77-80.

(6) Tembo, G., et al. Bed occupancy due to HIV/AIDS in an urban hospital medical ward in Uganda. *AIDS* 1994; 8(8):1169-71.

(7) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

United Republic of Tanzania

HIV/AIDS epidemiological summary

HIV information among antenatal clinic attendees has been available from Tanzania since the mid-1980s. In Dar es Salaam, the major urban area, HIV prevalence among antenatal clinic attendees tested increased from 4% in 1986 to 12% in 1995-96. Age detail is available for 1989, 1993 and 1995-96. In 1995-96, 7% of tested antenatal clinic attendees less than 20 years of age were HIV-positive. Peak infection occurred among the 25–29-year-old clinic attendees. Outside of Dar es Salaam, HIV information is available from sentinel surveillance reporting and from additional special studies. Median HIV prevalence increased from 3% in 1987 to 19% in 1998. In 1997, HIV prevalence among antenatal clinic attendees tested in the 14 reporting sites ranged from 4 to 44%.

Information on HIV prevalence among sex workers in Dar es Salaam has been available since the mid-1980s. HIV prevalence among tested sex workers increased from 29% in 1986 to 50% in 1993. Outside of Dar es Salaam, HIV information on sex workers is available from Kilimanjaro, Arusha, Moshi, Tanga, Dodoma, and Singida for 1988. Median HIV prevalence among sex workers tested in these areas was 19%, ranging from 8 to 32%. In 1992, 40% of sex workers tested in Mwanza town were HIV-positive and, in 1993, 61% of sex workers in Morogoro were HIV-positive. In Dar es Salaam, HIV prevalence among tested STI clinic patients increased from 13% in 1986 to 24% in 1994. In 1997, 13% of STI clinic patients tested were HIV-positive. Outside of Dar es Salaam, most of the data on HIV prevalence among STI clinic patients come from Mbeya. HIV prevalence among STI patients tested in Mbeya increased from 23% in 1988 to 27% in 1997.

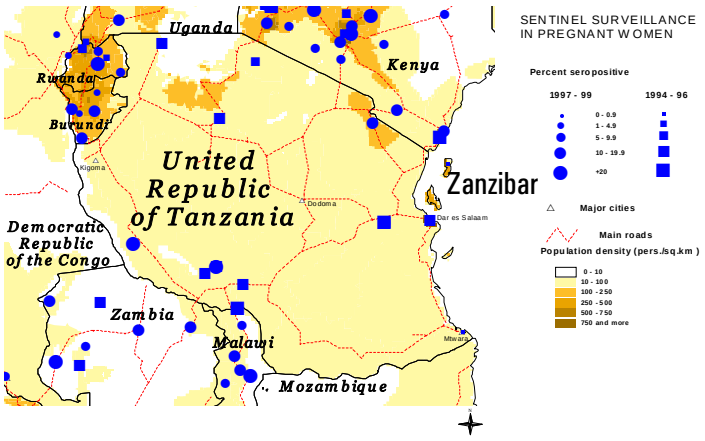
In Zanzibar, HIV prevalence among pregnant women ranged between 0.5% and 1.1% in 1999, whereas, in 1995, in three sentinel sites, HIV prevalence ranged between 2.4 and 8.9% (this information was provided by the acting programme manager of the Zanzibar AIDS Control Programme (ZACP) on 21 July 2000). The HIV prevalence among blood donors has increased from 0.5% in 1987 to 1.5% in 1998 (ZACP, July 2000).

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	1 300 000	1 200 000	8.09	670 000	59 000
Zanzibar	1086	1034		318	25

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	1 100 000	UNAIDS/WHO, June 2000
Zanzibar	-	-	-
Estimated AIDS deaths	1999	140 000	UNAIDS/WHO, June 2000
Zanzibar	1999	362	ZACP

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1996	15-19	25.4	18.7
Reported non-regular sexual partnership over a 12-month period (%)	1996	15-49	29.1	12.9
Zanzibar: data not available				

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1995	12.2	7.3	13.7
Zanzibar	1995	0.7	-	-



Economic impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact on Tanzania are relatively extensive compared with many other countries in sub-Saharan Africa. Of particular note is that much of the work in Tanzania is based on empirical data. The macroeconomic impact of AIDS has been estimated using a model developed by the World Bank in 2000. Of the sectors explored here, a World Bank study in Kagera in 1993 provides a picture of the impact of AIDS at the household level. Studies in the area of business and agriculture are still limited but show costs in terms of reduced labour time and increased medical and burial costs. In the area of education, a model developed by UNAIDS and UNICEF in 2000 shows how the rapidly increasing mortality rates in teachers have led to discontinuity in teaching, with many pupils losing or having a change in their teachers. Finally, the studies in health demonstrate that the health system is being stretched by the need to care for people with AIDS, and there is a large gap in funding to meet the full needs of a scaled-up care and prevention programme.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be approximately 0.7% by 2010 (1).

Economic impact of HIV/AIDS on households

A study in Kagera in 1993 showed that, among the poor, AIDS deaths led to a general consumption drop of 32% and food consumption drop of 15% (2). Similarly, when comparing households that had experienced a death in the previous year with those that had not, medical care expenses were 8% of total household expenditure, compared with 0.8%, respectively. In addition, households with an AIDS death spent, on average, 50% more on funerals than on medical care (3).

Economic impact of HIV/AIDS on agriculture

In Kagabiro, a case study survey in 1997 found that, in households where one person was sick as a result of AIDS, 29% of labour was spent on AIDS-related matters and the average household labour loss from agricultural activities was 43% if two people were devoted to nursing duties (4).

Economic impact of HIV/AIDS on firms

Supply: Empirical data from a range of businesses in Dar es Salaam showed the annual average medical costs per employee across six firms increased from 22.4 Tsh to 100.2 Tsh and burial costs from 700 Tsh to 4279 Tsh, between 1993 and 1997 (5).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 4 million primary school students, 49 000 children would have lost a teacher to AIDS in 1999 (6).

Demand: School attendance is reported to be cut in half among 15–20-year-olds if the household loses an adult female (7).

Economic impact on the health sector

Demand: In 1996, 50% of beds at Muhimbili Medical Centre, Dar es Salaam were occupied by those with AIDS-related illnesses (8).

Supply: Not available.

Resource gap: The annual cost of scaling-up HIV/AIDS activities is US$ 100 to US$ 156 million (9).

Economic impact of HIV/AIDS Zanzibar

Summary of the economic impact of HIV/AIDS

No information available.

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements: Will be endorsed by the cabinet in June/July 2000. The policy covers HIV/AIDS prevention, control care and support, and reinforces the need for respect of human rights and avoidance of discrimination and stigmatization.

Source: NACP and final draft policy document.

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health (integrated into the health policy)	X	
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: NACP

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: NACP

Date: June 2000

Policy formulation in Zanzibar

Existence of national HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key element: Draft policy has been initiated and is awaiting review before it is finalized and endorsed.

Source: ZACP

Date: July 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education		X
Health		X
Military		X
Workplace		X
Sports		X
Others		X

Comments/Key elements:

Source: ZACP

Date: July 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	X

Comments/Key elements:

Source: ZACP

Date: July 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: A National Advisory Board on AIDS (NABA) was established by the Prime Minister and is headed by the Former President H. E. Mwinyi. A National AIDS Committee (NAC), which is inter-ministerial and is chaired by the Principal Secretary in the Prime Minister's office, is in place. Both high-level bodies will improve in effectiveness as they are strengthened.

Source: NACP and Documents

Date: June 2000

Organizational structure Zanzibar

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements: Although high-level structure exists (National Aids Committee), it is not yet functioning.

Source: ZACP

Date: July 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X (1998–2002)	

Comments/Key elements: Sectoral and District plans of action exist for the period 2000 to 2002.

Source: NACP and Documents

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: 11 priority areas of focus for MTP III are clearly articulated.

Source: Strategic framework for the third medium term, 1998–2000 and documents

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
X	

Comments/Key elements: Government has allocated 4.8 billion Tsh (US$ 6 million) for HIV/AIDS activities in its budget for the fiscal year 2000/2001.

Source: NACP

Date: July 2000

Planning and programming Zanzibar

Existence of national strategic plan on HIV/AIDS

Yes	No
X (1998-2002)	

Comments/Key elements: Action Plans for 2000 to 2001 have been developed.

Source: ZACP

Date: July 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: Nine priority areas of focus for MTP III are clearly articulated.

Source: ZACP - Strategic framework for the third medium term, 1998-2000.

Date: July 2000

Existence of budget for implementation of the national strategic plan

Yes	No

Comments/Key elements: Although the strategic plan 1998 - 2002 and the workplan 2000 - 2001 have been budgeted, there is no information on the actual budgetary allocations for implementation of activities.

Source: ZACP

Date: July 2000

General demographic and socioeconomic indicators

Demographic indicators	Year	Estimate	Source
Total population (thousands)	1999	32 793	UNPOP
Population aged 15–49 (thousands)	1999	14 991	UNPOP
Annual population growth (%)	1990–1998	2.9	UNPOP
% of population urbanized	1998	25	UNPOP
Average annual growth rate of urban population (%)	1990-1998	5.1	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	210	World Bank
GNP per capita average annual growth rate (%)	1996-1997	1.2	World Bank
Human Development Index rank (HDI)	2000	156	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	68	UNESCO
Adult male literacy rate	1995	79	UNESCO
Adult female literacy rate	1995	57	UNESCO
Male secondary school enrolment ratio	1996	5.6	UNESCO
Female secondary school enrolment ratio	1996	4.9	UNESCO

Health Indicators	Year	Estimate	Source
Crude birth rate (births per 1000 pop.)	1999	41	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	15	UNPOP
Maternal mortality rate (per 100 000 live births)	1990	770	WHO
Life expectancy at birth	1998	48	UNPOP
Total fertility rate	1998	5.4	UNPOP
Infant mortality rate (per 1000 live births)	1999	80	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990–1999	18	UNICEF/UNPOP
% of births attended by trained health personnel	1990–1999	38	UNICEF
% of one-year-old children fully immunized (DPT)	1995–1998	74	UNICEF

General demographic and socioeconomic indicators Zanzibar

Demographic indicators Zanzibar	Year	Estimate	Source
Total population (thousands) projected for 2000	2000	867	ZACP
Population aged 15-49 (thousands)	-	-	-
Annual population growth (%)	1978-1988	3	ZACP
% of population urbanized	2000	35	ZACP
Average annual growth rate of urban population (%)	-	-	-
Economic Indicators Zanzibar	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1998	222	ZACP
GNP per capita average annual growth rate (%)	-	-	-
Human Development Index rank (HDI)	-	-	-
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators Zanzibar	**Year**	**Estimate**	**Source**
Total adult literacy rate	-	-	-
Adult male literacy rate	-	-	-
Adult female literacy rate	-	-	-
Male secondary school enrolment ratio	-	-	-
Female secondary school enrolment ratio	-	-	-
Health Indicators Zanzibar	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	-	-	-
Crude death rate (deaths per 1000 pop.)	-	-	-
Maternal mortality rate (per 100 000 live births)	1998	377	ZACP
Life expectancy at birth	1998	48	ZACP
Total fertility rate	1998	9.6	ZACP
Infant mortality rate (per 1000 live births)	1998	75	ZACP
Contraceptive prevalence rate (%)	1997	21.5	ZACP
% of births attended by trained health personnel	-	-	-
% of one-year-old children fully immunized-DPT	-	-	-

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Over, M. and Mujinja. *The economic impact of adult mortality on consumption in the African household*. Washington DC: World Bank, 1995.

(3) Over, M., Ainsworth, M., et al. *Coping with AIDS: the economic impact of adult mortality from AIDS and other causes on households in Kagera*, *Tanzania*. 1996.

(4) Tibaijuka, A. K. AIDS and Economic Welfare in Peasant Agriculture: Case Studies from Kagabiro Village, Kagera Region, Tanzania. *World Development* 1997; 25(6):963-75.

(5) Clancy, P. *The Economic Impact of AIDS at Firm Level in Tanzania*. University of East Anglia, 1998.

(6) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(7) The Economic Impact of AIDS. *PHNFlash* 1995 Feb. (Issue 58).

(8) Outwater, A. The Socioeconomic impact of AIDS on women in Tanzania. In: Long LD, Ankrah EM, editors. *Women's Experiences with HIV/AIDS: an international perspective*. New York, NY, Columbia University Press, 1996.

(9) World Bank & UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Zambia

HIV/AIDS epidemiological summary

HIV prevalence information among antenatal clinic attendees has been available from Zambia since the mid-1980s. In Zambia, Lusaka and Ndola are the major urban areas. HIV prevalence among antenatal women tested in the major urban areas increased from 5% in 1985 to 27% in 1992 and remained stable at that rate through 1998. Although overall HIV prevalence rates have remained the same between 1992 and 1998, HIV prevalence among the youngest age group has declined. In 1993, 27% of tested antenatal clinic women less than 20 years of age were HIV-positive. By 1998, that rate had declined to 17%. In 1994 and 1998, HIV prevalence among antenatal clinic women outside the major urban centres remained stable at 14%. HIV prevalence ranged from 5% to 31% among women tested in 18 sites in 1998. In 1994, 14% of antenatal clinic women less than 20 years of age who were tested outside of the major urban areas were HIV-positive. This rate declined to 6% in 1998.

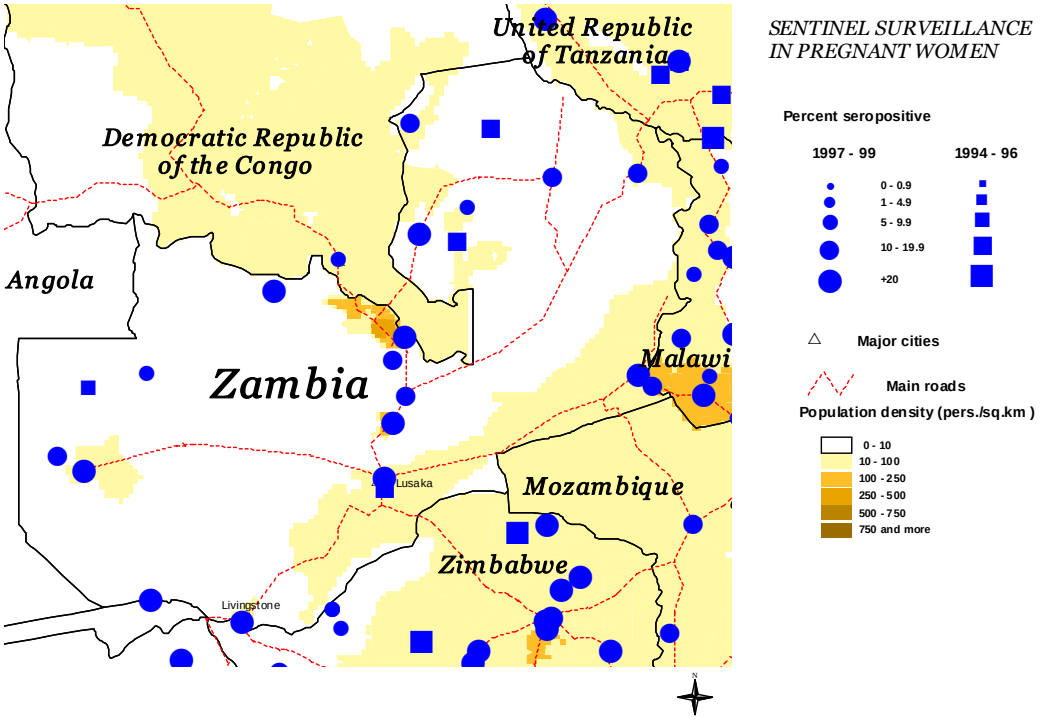
In 1991, 60% of male STI patients and 69% of female STI clinic patients tested in Lusaka were HIV-positive. Outside of Lusaka, 41% of female STI patients tested were HIV-positive.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	870 000	830 000	19.95	450 000	40 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	650 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	99 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent intercourse with a non-regular partner (%)	1998	15–49	33	24
Reported non-regular sexual partnership over a 12-month period (%)	1998	15–49	39.3	16.8

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1998	27	25.9	29.1



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact of AIDS on Zambia are extensive, although some areas need updating. Of the sectors explored here, the impact on both health and education is very clear. The health system is being stretched by the need to care for people with AIDS and there is still a large gap in funding to meet the costs of a scaled-up care and prevention programme. In the education sector, household studies have shown the reduced school attendance as a direct result of AIDS and, on the supply side, a UNAIDS/UNICEF model shows the impact of AIDS-related mortality on teaching. Finally, studies in the area of business and agriculture are still limited but show costs in terms of increased medical and burial expenses. There is a need for further work in both these areas to help formulate appropriate responses to the epidemic in Zambia.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 1.15% by 2010 (1).

Economic impact of HIV/AIDS on households

In a recent study of two areas in Kafue, AIDS-affected households reported annual income levels of 30–35% less than unaffected households (2). Focus group discussions with families of AIDS patients in Mansa District found that 60% perceived malnutrition to be a major risk (3) and an analysis of 49 case studies of families of AIDS patients found half facing food shortages (4). A separate survey of 116 families of AIDS patients throughout Zambia found that 59.8% faced food shortages (5).

Economic impact of HIV/AIDS on agriculture

Not available

Economic impact of HIV/AIDS on firms

The costs to INDENI Petroleum for AIDS-related medical and funeral expenses in the early 90s exceeded their profits of US$ 24 500 (6).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 1.7 million primary school students, 56 000 would have lost a teacher to AIDS in 1999 (7). The number of teacher deaths in 1998 was equivalent to the loss of about two-thirds of the annual output of newly trained teachers (8).

Demand: Focus Group discussions with AIDS-affected households in Mansa District found that 55% of these households were unable to meet the costs of children's education as a result of AIDS (3). An analysis of 49 case studies of families affected by AIDS throughout Zambia found that 56 of 215 children had been forced to leave school (4). A survey of 116 AIDS-affected families found that 42% of children had stopped attending school (5).

Economic impact on the health sector

Supply: Mortality for health care workers in two hospitals increased 13-fold between 1980 and 1990, with death certificates indicating that the rise was largely due to HIV (9).

Demand: As of 1993, over 50% of bed occupancy was due to AIDS and, at Monze and Choma hospitals, 43% and 47%, respectively, of bed days were taken up by HIV-related disease (10). AIDS care expenditures are projected to rise from US$ 1.7 million in 1990 and US$ 12.9 million in 1995 to US$ 21 million in 2005 (11).

Resource gap: The annual cost of scaling-up HIV/AIDS programmes is estimated to be between US$ 35 and US$ 55 million (12).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
	x

Comments/Key elements:

Source: UNAIDS ZAMBIA

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		
Education	x	
Health		
Military		
Workplace		
Sports		
Others		

Comments/Key elements:

Source: UNAIDS ZAMBIA

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
	x

Comments/Key elements:

Source: UNAIDS ZAMBIA

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
x	

Comments/Key elements: A national HIV/AIDS/STD/TB Council and Secretariat has been announced, but not yet set up.

Source: UNAIDS Zambia

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
x	

Comments/Key elements: A Strategic Framework for the national response to HIV/AIDS has been completed.

Source: UNAIDS Zambia

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements:

The Strategic Framework identifies the following priority areas:

Geographical: Lusaka, Copperbelt Province, districts along the main trucking routes; districts with well-defined fishing areas in Luapula Province and Southern Province; districts with seasonal workers in rural areas; districts with refugee populations and towns with frequent cross-border traders.

Sub-populations: people living with HIV/AIDS, orphans in and out of school, commercial sex workers, public sector workers, private sector workers, and men.

Interventions: promotion of multisectoral response, promotion of behaviour change, STI control, de-stigmatization of HIV/AIDS, voluntary counselling and testing, reducing mother-to-child transmission, home-based care and support for people living with HIV/AIDS, community-based support for orphans and vulnerable children, and improved hospital care.

Source: UNAIDS Zambia

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements: the second phase of the Strategic Framework for the national response to HIV/AIDS is currently being costed, after which there will be a donors' pledging meeting.

Source: UNAIDS Zambia

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total Population (thousands)	1999	8976	UNPOP
Population aged 15-49 (thousands)	1999	4102	UNPOP
Annual population growth (%)	1990-1998	2.4	UNPOP
% of population urbanized	1998	43	UNPOP
Average annual growth rate of urban population (%)	1990-1998	2.7	UNPOP
Economic Indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	370	World Bank
GNP per capita average annual growth rate (%)	1996-1997	1.8	World Bank
Human Development Index rank (HDI)	2000	153	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education Indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	78	UNESCO
Adult male literacy rate	1995	86	UNESCO
Adult female literacy rate	1995	71	UNESCO
Male secondary school enrolment ratio	1996	35.1	UNESCO
Female secondary school enrolment ratio	1996	22.2	UNESCO
Health Indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	42	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	20	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	940	WHO
Life expectancy at birth	1998	40	UNPOP
Total fertility rate	1998	5.5	UNPOP
Infant mortality rate (per 1000 live births)	1999	80	UNICEF/UNPOP
Contraceptive prevalence rate (%)	1990-1999	26	UNICEF/UNPOP
% of births attended by trained health personnel	1990-1999	47	UNICEF
% of one-year-old children fully immunized-DPT	1995-1998	70	UNICEF

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Mutangadura, G. and Webb, D. (1998/99) The socio-economic impact of adult mortality and morbidity on urban households in Zambia. *AIDS analysis Africa* 9(4): Dec 98/Jan 99.

(3) Kasawa (1993) unpublished report.

(4) Haworth, A., Kalumba, K. et al. (1991) Paper presented to VII International Conference on AIDS, Florence 1991.

(5) Haworth, A. (1991) A study of the effects of AIDS upon the children in 116 Zambian families. Unpublished.

(6) ILO EAMAT (1995) *The impact of HIV/AIDS on the productive labour force in Zambia*. EAMAT Working Paper No. 5. Addis Ababa.

(7) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(8) Kelly, M.J. *The Impact of HIV/AIDS on Schooling in Zambia*. Paper presented at XIth International Conference on AIDS and STDs in Africa (ICASA), September 1999.

(9) Buve, A, Foster S, Mbwili C, Mungo E, Tollenare N et al (1994) Mortality among female nurses in the face of the AIDS epidemic: a pilot study in Zambia. *AIDS* 8(3):396.

(10) Foster, S. (1993) *Cost and Burden of AIDS on the Zambian Health Care System: Policies to Mitigate the Impact on Health Services*. Lusaka: USAID, London School of Hygiene and Tropical Medicine.

(11) Ministry of Health and Central Board of Health (1997) HIV/AIDS in Zambia: Background projections, impacts and interventions. December 1997.

(12) World Bank and UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, 2000.

Zimbabwe

HIV/AIDS epidemiological summary

Information on HIV prevalence among antenatal clinic attendees has been available from Zimbabwe since 1989. In the major urban areas, Harare, Bulawayo, and Chitungwiza, HIV prevalence among antenatal clinic attendees tested increased from 10% in 1989 to 36% in 1994. In 1997, 30% of antenatal clinic attendees tested HIV-positive. Age detail is available from Harare in 1995 only. Twenty-six per cent of antenatal clinic attendees less than 20 years of age (which included 28% of women 15-17 years of age) tested positive for HIV.

Outside Harare, sentinel surveillance information among antenatal clinic attendees has been available since 1990. Since then, HIV prevalence among tested antenatal clinic attendees increased from 12% in 1990 to 37% in 1995. In 1997, a median of 30% of antenatal clinic women tested in 31 sites were HIV-positive. In Masvingo, in 1995, where 42% of antenatal clinic attendees tested were HIV-positive, 34% of women less than 20 years of age were HIV-positive. Peak infection occurred among women 20-24 years of age: 49% tested positive for HIV.

There is only one study available with information on HIV prevalence among sex workers in Zimbabwe. In 1994–95, 86% of sex workers tested in Harare were HIV-positive.

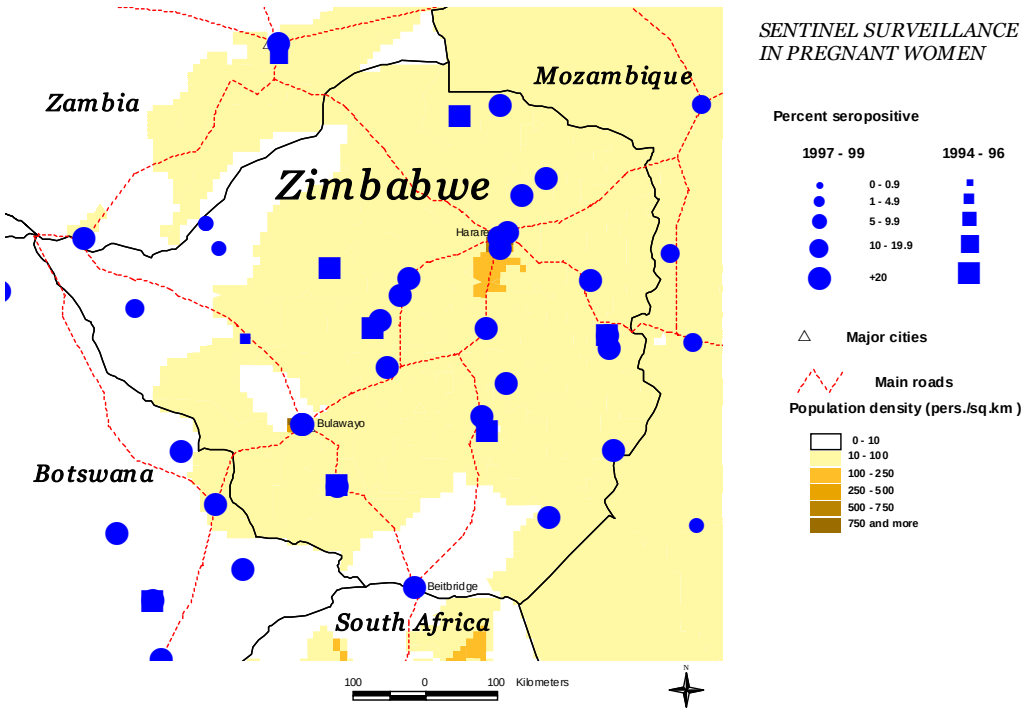
In Harare, HIV prevalence among STI clinic patients tested increased from 52% in 1990 to 71% in 1995. Outside Harare, HIV prevalence among STI clinic patients increased from 6% in 1987 to 72% in 1996.

Estimated number of people living with HIV/AIDS, end 1999	Adults and children	Adults (15-49)	Adult rate (%)	Women (15-49)	Children (0-14)
Source: UNAIDS/WHO, June 2000	1 500 000	1 400 000	25.06	800 000	56 000

Demographic impact of HIV/AIDS	Year	Estimate	Source
Children who lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic	1999	900 000	UNAIDS/WHO, June 2000
Estimated AIDS deaths	1999	160 000	UNAIDS/WHO, June 2000

Behavioural indicators	Year	Age group	Male	Female
Reported condom use during most recent Intercourse with a non-regular partner (%)	-	-	-	-
Reported non-regular sexual partnership over a 12-month period (%)	-	-	-	-

Measured HIV prevalence	Year	Median	Min.	Max.
Women in antenatal care clinics – major urban areas (%)	1997	29.7	24	33.3



Economic Impact of HIV/AIDS

Summary of the economic impact of HIV/AIDS

Data on the economic impact on Zimbabwe are relatively extensive as compared with many other countries in sub-Saharan Africa. The macroeconomic impact of AIDS has been estimated using a recent model, and preliminary results show a considerable impact on the economy as a whole. Of the sectors explored here, a survey in 2000, exploring the impact of AIDS-related female mortality, reveals its devastating impact on the household and consequent reduction in school enrolment rates. Studies in the area of agriculture show a reduction in production, while studies in the business sector show rising production costs due to AIDS-related morbidity and mortality. In the area of education, a UNAIDS/UNICEF model shows that increasing mortality rates have led to discontinuity, with many pupils losing or having a change in their teachers. In health, a study in costing AIDS-related hospitalizations shows bed occupancies of 50% due to AIDS and increased lengths of stay. No studies have explored the issue of supply in health care or the impact of rising mortality rates in health care workers. Finally, a model of resource requirements for AIDS in health demonstrates that there is a large gap in funding required to meet the full needs of a scaled-up care and prevention programme, equivalent to US$ 4.5–7 per capita and 1.4% of GDP.

Macroeconomic impact

Preliminary results of a model developed in 2000 estimate the annual loss in GDP growth per capita as a result of AIDS to be 1.4 % by 2010 (1).

A model in 1993 estimated that, in the absence of foreign assistance, the annual growth rate of GDP might be 25% lower in 2000 than it would have been without AIDS (2).

Economic impact of HIV/AIDS on households

In 1997, a bedridden AIDS patient was estimated to cost an additional US$ 23–34 per month to households (3), (4). The average cost for a funeral in 1998 was Z$ 4500 (5). In a survey in 2000 to assess the impact of adult female mortality in two districts, it was found that 65% of households where the deceased female had lived were no longer in existence (6).

Economic impact of HIV/AIDS on agriculture

A survey by the Zimbabwe Farmers' Union and the Friedrich Ebert Stiftung Economic Advisory Group, carried out in two districts in 1997, found a reduction of 50% in smallholder production in households with an AIDS death, ranging from 29% for cattle ownership, 37% for groundnuts, 49% for vegetables, and 47% for cotton to 61% in maize (7).

Economic impact of HIV/AIDS on firms

Supply: The cost of AIDS to the National Railways of Zimbabwe in 1997 was found to be equivalent to 20% of company profits (8), (9). A 1993 study estimated that training costs, due to the replacement of skilled workers, would increase five-fold by 2000 (2).

Economic impact of HIV/AIDS on education

Supply: A model developed by UNAIDS and UNICEF in 2000 shows that, of around 2.4 million primary school students, 86 000 would have lost a teacher to AIDS in 1999 (10).

Demand: In a survey in 2000 to assess the impact of adult female mortality in two districts, it was found that 31% of households interviewed had a child who was not attending school after the death of a mother (6).

Economic impact on the health sector

Supply: Not available

Demand: In 1994/5, bed occupancy due to HIV/AIDS was 50% (3). Staff estimates were that 50-70% of bed occupancy was HIV-related in 1998 in some government hospitals. AIDS treatment costs, excluding antiretroviral therapy, as a percentage of the Ministry of Health and Child Welfare budget, are projected to be 61% by 2005 (11).

Resource gap: The scaling-up of HIV/AIDS programmes nationwide is estimated to cost between US$ 55 million and US$ 90 million per year (12).

Management and implementation of the national response to HIV/AIDS

Policy formulation

Existence of National HIV/AIDS policy (either a written document or part of one)

Yes	No
X	

Comments/Key elements:

Source: UNAIDS Zimbabwe

Date: June 2000

Existence of HIV/AIDS policy in the following sectors:

Sector	Yes	No
Agriculture		X
Education	X	
Health	X	
Military		X
Workplace	X	
Sports		X
Others		

Comments/Key elements:

Source: UNAIDS Zimbabwe

Date: June 2000

Existence of HIV/AIDS-specific legislation against discrimination on the grounds of HIV

Yes	No
x	

Comments/Key elements:

Source: UNAIDS Zimbabwe

Date: June 2000

Organizational structure

Existence of high-level structure in support of the national response

(e.g. National AIDS Committee/Commission, Inter-Ministerial Committee, Presidential-level bodies)

Yes	No
X	

Comments/Key elements:

A National AIDS Council was established in March 2000, including representatives from government, NGOs, religious organizations, private sector, mass media. The President will be patron of the Council. The Council has a secretariat, which will operate under the Ministry of Health. The director and other staff of the secretariat are still to be appointed.

The current NACP is under the Ministry of Health. To date, it has been responsible for promoting a multisectoral response. With the creation of the National AIDS Council and secretariat, the role of this unit will change to that of coordinating Ministry of Health activities in HIV/AIDS.

Source: UNAIDS Zimbabwe

Date: June 2000

Planning and programming

Existence of national strategic plan on HIV/AIDS

Yes	No
X	

Comments/Key elements: A national strategic framework for the national response to HIV/AIDS has been completed and was approved by the National AIDS Council in May 2000.

Source: UNAIDS Zimbabwe

Date: June 2000

National strategic plan on HIV/AIDS includes clearly identified priorities

Yes	No
X	

Comments/Key elements: The core objective of the national strategic framework for the national response to HIV/AIDS is prevention. Focus is also given to mitigation of HIV/AIDS impact through care and psycho-social support, coordination and management of a multisectoral response, resource mobilization and community involvement.

Source: The national strategic framework for the national response to HIV/AIDS, draft/UNAIDS Zimbabwe

Date: June 2000

Existence of budget for implementation of the national strategic plan

Yes	No
	X

Comments/Key elements:

Source: UNAIDS Zimbabwe

Date: June 2000

General demographic and socioeconomic indicators

Demographic Indicators	Year	Estimate	Source
Total population (thousands)	1999	11 529	UNPOP
Population aged 15-49 (thousands)	1999	5768	UNPOP
Annual population growth (%)	1990-1998	1.8	UNPOP
% of population urbanized	1998	33	UNPOP
Average annual growth rate of urban population (%)	1990-1998	3.7	UNPOP
Economic indicators	**Year**	**Estimate**	**Source**
GNP per capita (US$)	1997	720	World Bank
GNP per capita average annual growth rate (%)	1996-1997	-0.1	World Bank
Human development index rank (HDI)	2000	130	UNDP
% population economically active	-	-	-
Unemployment rate	-	-	-
Education indicators	**Year**	**Estimate**	**Source**
Total adult literacy rate	1995	85	UNESCO
Adult male literacy rate	1995	90	UNESCO
Adult female literacy rate	1995	80	UNESCO
Male secondary school enrolment ratio	1996	52.2	UNESCO
Female secondary school enrolment ratio	1996	44.5	UNESCO
Health indicators	**Year**	**Estimate**	**Source**
Crude birth rate (births per 1000 pop.)	1999	31	UNPOP
Crude death rate (deaths per 1000 pop.)	1999	19	UNPOP
Maternal mortality rate (per 100,000 live births)	1990	570	WHO
Life expectancy at birth	1998	44	UNPOP
Total fertility rate	1998	3.8	UNPOP
Infant mortality rate (per 1000 live births)	1999	69	UNPOP
Contraceptive prevalence rate (%)	1990-1999	66	UNICEF/UNPOP
% of births attended by trained health personnel	1990-1999	69	UNICEF/UNPOP
% of one-year-old children fully immunized-DPT	1995-1998	70	UNICEF/UNPOP

References

(1) Bonnel, R. *What Makes an Economy HIV-Resistant?* Draft report presented during the International AIDS Economic Network Symposium, Durban, South Africa, 7-8 July 2000.

(2) Forgy, L. *The economic impact of AIDS in Zimbabwe*. 1993. REDSO/ESA.

(3) Hansen, K. et al. The cost of home-based care for HIV/AIDS patients in Zimbabwe. *AIDS Care* 1998; **10**(6):751-9.

(4) Harnmeijer, J. *The Economic Impact of HIV/AIDS on households in Zimbabwe*. 1997. Waterford Kamhala, United World College of Africa.

(5) Ncube, J. Death as a profitable business venture. *AIDS Analysis Africa* 1997.

(6) Mutangadura, G. *Household welfare impacts of mortality of adult females in Zimbabwe: Implications for policy and program development*. Paper presented to The International AIDS and Economics Network Symposium, Durban, South Africa, 7-8 July 2000.

(7) Kwaramba, P. *The socio-economic impact of HIV/AIDS on communal agricultural systems in Zimbabwe*. Working paper 1997. Harare, Zimababwe, Zimbabwe Farmers Union, Friedrich Ebert Stiftung Economic Advisory Project. 1997

(8) National Railways Zimbabwe. *Presentation at the Inter-sectoral Committee on AIDS & Employment*, (National Meeting on Impact and Interventions in IDS and Employment), Jameson Hotel, Harare. 7 April 1997 (unpublished).

(9) Roberts, M. and Rau, B. *Private Sector AIDS Policy African Workplace Profiles: Case Studies on Business Managing HIV/AIDS*. 1997. The AIDSCAP Electronic Library.

(10) UNICEF. *The Progress of Nations 2000*. Background paper. New York, UNICEF, 2000.

(11) National AIDS Coordination Programme, Ministry of Health and Child Welfare. *HIV/AIDS in Zimbabwe: Background, Projections, Impact, Interventions*. Harare, National AIDS Coordination Programme, 1998.

(12) World Bank & UNAIDS. *Costs of Scaling HIV Programmes to a National Level for Sub-Saharan Africa*. Draft report, April 2000.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners - governmental and NGO, business, scientific and lay - to share knowledge, skills and best practice across boundaries.

Produced with environment-friendly materials

UNAIDS/ECA

AIDS in Africa

Country by country

Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNAIDS - 20 avenue Appia - 1211 Geneva 27 - Switzerland
Telephone: (+41 22) 791 46 51 - Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org - Internet: http://www.unaids.org