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**Author**

Costa, Patricia R.

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The Relationship between Economic Growth and  
HIV/AIDS in Southern Africa:  
A Review of the Literature

Patricia R. Costa

**Abstract**

*The objective of this paper is to explore the relationship between economic growth and HIV/AIDS analyzing possible causes and reviewing pertinent literature in order to try to disclose relationships not adequately explored to date. The paper does not focus on AIDS transmission but on vulnerability to AIDS. In brief, it argues that economic growth has, in the case of Southern Africa, been accompanied by disruption and deprivation, which, in turn, created vulnerability to AIDS by increasing poverty, disease and malnutrition. Therefore, this review suggests that the correlations among poverty, inequality and economic growth in Southern Africa need to be investigated more thoroughly in order to understand the HIV/AIDS pandemic in the region.*

## Review of Literature

Africa's present situation is one of global warning: Southern Africa has 10 percent of the world's population and 70 percent of the world's HIV/AIDS-infected people (UNICEF 2001) (see Table 1 in the appendix). While HIV/AIDS previously was seen as a biomedical matter, recent research suggests that inequality and poverty fuel the epidemic just as critically (e.g. Wilkinson 1996; World Bank 1997; Stillwaggon 2000, 2002, 2005). Accordingly, it is assumed that the macroeconomic interests in "economic growth," which dominated the development path, characterized by unequal power relationships, contributed greatly to the present poverty in Southern Africa — the main "feeder" of AIDS in the region. Still, the review will not engage in discussing "Whose fault is it?" but will attempt to show that the problem is that economic growth per se does not increase well-being unless accompanied by a more equal distribution of wealth.

Economic growth has always been strongly associated with the upsurge of wealth and health. With the emergence of development theories in post-World War II, economic growth became increasingly associated with development and, for years to come, the former would be pursued in the quest for the latter. Surely, modernization has had a positive impact on health by decreasing mortality rates and dramatically improving life expectancy (Kunitz 1994). In post-war Britain, economic growth statistically has been associated with a decrease in mortality, through a decline of infections and communicable diseases (Szreter 2001). Furthermore, 19<sup>th</sup> century Holland, Germany, France, Australia, Canada, the United States, and early 20<sup>th</sup> century Japan (*ibid*) all have exhibited the same path as Britain. In

sum, history seemed to justify assuming that modernization<sup>1</sup> leads to improvements in economic well-being and consequently to greater health (Kunitz 1994).

Despite economic growth being equated with life improvement, one cannot conclude a causal relationship between the two (Carpenter 2000) because in Southern Africa economic growth has not led to increases in health and well-being, but rather to increases in HIV/AIDS infection rates (Youde 2001). Understanding the "social production" (Schoepf 2001, Barnett 2005, Poku 2005) of HIV/AIDS is of extreme importance when we talk about both the development path and the disease path in Southern Africa. As Louis Pasteur said, "*the microbe is nothing, the terrain everything*" (cited in Stillwaggon 2002: 2).

Writers like Singer (1998) bring a new light into the discussion by highlighting the epidemic's social and political determinants. This author shows that the epidemic can be an expression of social relationships when these relationships restrict access to health care resources and, consequently, feed disease transmission. During the 1980s economic crisis, the international financial scenario that pressured strongly for the prioritization of economic growth has seemingly done so at the expense of investment in poverty reduction program in third world countries. This neglect has been cyclical with the increase of poverty, which fueled the spread of vulnerability to the virus (Ainsworth and Dayton 2003; Karim and Karim 2005).

According to Sen (1989, 1999), if the individual lives in a context of "unfreedom," where he or she cannot develop his or her capabilities, that individual will progress little in all aspects of development.<sup>2</sup> The important concept here is *vulnerability*: Southern Africa hosts most of the poorest countries in the world. Despite some countries succeeding

economically, overall, the poorest countries in the region were worse off in 1991 than in 1983. Similarly, Garrett (1994) reminds us that already in the 1960s René Dubos was writing at length about the particular vulnerability that poor people have to microbes:

The old adage — that if it doesn't kill you, it makes you stronger — is unfortunately not true. Recurrent malnutrition, infectious disease and parasite infestation, if they don't kill you, make you weaker (Stillwaggon 2002: 10).

Dubos argued that the history of disease repeatedly has been associated with “weak points of economically bereft lives” (e.g. chronic malnutrition, prostitution, poor hygiene, etc.) (Garrett 1994: 475). Thus, HIV infection, as with other infectious diseases, is influenced by factors that exploit host vulnerability, such as general poor health,<sup>3</sup> little access to health services<sup>4</sup> and being economically disadvantaged<sup>5</sup> (see Poku 2004, 2005). As one can conclude easily, all these conditions are met in Southern African countries to a degree not mirrored in any other region in the world (Stillwaggon 2002, 2005).

It appears that although economic growth increases the availability of resources for poverty and vulnerability reduction, income distribution is a stronger determinant of the overall well-being of the poor and a factor in the decrease of vulnerability to the conditions that facilitate the spread of HIV/AIDS. Suitably, AIDS came to stand for “Acquired *Income* Deficiency Syndrome”; it is a disease brought on more by conditions of economic “survival” than by promiscuity (Schoepf 2001). This argument is strengthened if we take into account Sen's readings on poverty (1989, 1999). Sen defines poverty as the deprivation of basic capabilities rather

than merely low levels of income. Although level of income is an identification of poverty, it is only instrumentally significant. That is, it is a means to understand poverty and not an end definition in itself. In this sense, I hope, it is easier to understand why inequality more than income encapsulates real measures of welfare.

Although the relationship between inequality, poverty and infectious disease or HIV infection is not straightforward (Barnett and Whiteside 2002), the existence of the relationship increasingly has been demonstrated (Wilkinson 1996; World Bank 1997; Stillwaggon 2000, 2002, 2005; Barnett 2005). A rough presentation of the numbers is highly suggestive. Botswana and Zimbabwe have the highest rates of HIV/AIDS in Africa in conjunction with the highest social inequality as measured by Gini coefficients (Stillwaggon 2002). Furthermore, African countries that have succeeded in increasing their GDP have the highest HIV/AIDS rates in the region and have failed to distribute income more equally (Stillwaggon 2002, 2005). Thus, it seems that income inequality and inequalities in health "march hand in hand" (Carpenter 2000: 340).<sup>6</sup>

Thus, despite economic growth historically being associated with wealth and health, Szreter's (2001) research runs contrary to this long-held opinion. Szreter demonstrates that during their earlier phases of ascending economic growth the population of many of these "famous" examples of successful development actually have experienced significant retardation or even stagnation of their health and welfare levels. In the author's words, "nothing inherent in the process of economic growth provides protection against its unwanted consequences—the 4 Ds": disruption, deprivation, disease and death (Szreter 2001: 78). Thus, economic growth should not be associated automatically

with development as it always places serious strains on the health of the population. While the 4 Ds are all potential outcomes of rapid economic growth, the first D, disruption, is a universal accompaniment of the process. Szreter describes disruption as the institutional and administrative destruction and construction, and the political conflict among the competing social groups involved, some of them newly formed social agents of economic change (2001). With regard to HIV/AIDS, by creating disruption, economic growth increases populations' vulnerability, which, as discussed earlier, is "food for AIDS."

Despite economic growth being equated with life improvement, a causal relationship between the two has not been proven (Carpenter 2000). Kunitz argues, "What better measure of progress is there than the health and well-being of entire populations?" (1994: 149). What does it mean that Southern Africa compounds both the highest per capita income on the continent as well as the highest HIV/AIDS infection rate in the world (Youde 2001)?

For example, through the 1990s, Botswana was one of the world's fastest growing economies and it presently suffers one of the worst AIDS epidemics in Africa. According to Youde (*ibid*), Szreter's theory of disruption explains the current AIDS epidemic in Southern Africa. Youde argues that Southern Africa is a victim of its own success because its rapid and disruptive economic growth did not allow for effective adaptation to the changes inherent to that economic growth:

Southern Africa's good fortune of attracting foreign investment and developing its own resources might have, perversely, indirectly led to the region becoming the epicenter to the AIDS epidemic (*ibid*: 26).

According to Youde (*ibid*), rapid economic growth often explains disease as a result of new, unaffordable medical fees, people's movement to new urban areas (often accompanied by unsanitary conditions) and increased wealth to purchase sex. In addition, Youde argues that Szepter's conceptualization of disruption is applicable to the present situation in most of Southern Africa as seasonal and permanent labor migration,<sup>7</sup> together with the highest rate of urbanization,<sup>8</sup> created an extreme fertile terrain and easy route for HIV. Without rapid growth HIV would have remained within the boundaries of smaller populations. Overall, as Kunitz argues, it seems that whatever impact one assumes that growth will have on health, "modernization has a natural history with inevitable health consequences" (1994: 149).

Economic growth is just like the free market; performance depends on good management. Thus, recent studies (Leys in Lunn 2002b) show that the mismanagement of economic gains will not reverse growth but rather will fail to secure improved quality of life. In other words, there is nothing inherent in economic growth that will guarantee an increase in quality of life. For example, among countries in Southern Africa, only Botswana, Cape Verde, Lesotho and Uganda had achieved higher per capita income in the mid-1990s than the prior decade; while Uganda and Cape Verde exhibit low rates of infection and low prevalence of AIDS, both Botswana and Lesotho have remarkably high rates of infection and high prevalence of the disease.

Stillwaggon (2002) has done some research into the study of the correlation between HIV prevalence and per capita income. As Stillwaggon recognizes, because an increase in income can be associated with migration, social disruption and increasing inequality and poverty, an increase



in per capita income often is correlated positively with HIV prevalence. Stillwaggon's study of the relationship between HIV prevalence and growth in GDP per capita in 44 countries<sup>9</sup> performed inconsistently, showing significant and positive correlations between HIV prevalence and growth in GDP per capita with only one of the two measures she used.<sup>10</sup> The perhaps counterintuitive finding did not surprise Stillwaggon, as she argues that rapid growth in GDP per capita in many of these countries was accompanied by rapid growth of income inequality.

Inequality in Africa is a much better indicator of a state's will of agency for adequately using its resources. For example, one of the fast-growth economies in Southern Africa is Botswana, where GDP per capita grew 8.5 percent per year from 1975 to 1990. However, this growth has coincided with growing inequality whereby "the number of people categorized as 'permanent destitutes' has increased five times as fast as total population since 1980" (Good 1999 in Stillwaggon 2002: 6). Supporting this, Stillwaggon (2002) found a very strong positive correlation between unequal income distribution and prevalence of HIV in Southern Africa. Thus, it appears that growth without equality intensifies vulnerability. In other words, inequality affects growth so badly that it actually undoes growth (Goldstein 2002). Likewise, estimates between 1981 and 1991 in Kenya showed that economic growth could have reduced poverty by more than 6 percent. However, worsening inequalities over the same period could account for an increased 3.5 percent in poverty (*ibid*). Evidence does not end here. Zimbabwe, has one of the highest rates of HIV in the world and, in 1980, the per capita income ratio of whites to that of urban blacks and rural blacks was 39:5:1 (Barry et al. 1990, Stillwaggon 2002). Overall, it appears

that resources cannot account for change. That is, growth only becomes development when it is solid and spread throughout society.

The demands made by the International Financial System (IFS) on Southern African countries may produce economic growth but also cause disruptions that contribute to an increased context of vulnerability in this world region. Economic growth in Southern Africa has widely been accompanied by country indebtedness, which has perpetuated vulnerability levels in Africa (i.e. poverty and incapacity to access health services). Suitably, Singer (1998) roots disease transmission, delivery of health care and prevention activities within the social inequality, power disparity and unequal access to resources created by the capitalist system at the global and local level.

According to Drèze and Sen (1989), famine results from an economic system's regulation of people's ability to acquire goods so that, in short, food availability is a question of income distribution. Likewise, AIDS appears to result from this same inability to hold entitlements, to follow the authors' terminology. Thus, the same way hunger and famine are a matter of income distribution, AIDS, also a form of deprivation, is a matter of income distribution and access to health. Or, shortly, food is for famine what health is for AIDS. Barnett and Whiteside (2002) compare Sen with Polanyi (1945) in the sense that, although market mechanisms are now "disembedded" from social relations, in the past, the opposite occurred. In this sense, public policy is the key to mitigate the suffering of the poor. As it follows, political implications are varied as the shift moves from "how much money does a government have?" into "how do rich and poor countries manage the resources they have?" Sen (1989, 1999), Schoepf (2001) and Szreter (2001) share the

same view. As Szreter (2001) argues, his view is of the same mind as Marx and Engels in the sense that both look at economic growth as intrinsically dangerous and socially destabilizing. However, Szreter (2001) does not see the relationship between "capital" and "labor," or growth and development as irreconcilable or deterministic. Thus, as the England demonstrated historically, despite health and disease being related strongly to processes of social change and development, managing health problems in late-developing countries undoubtedly must involve social and economic development (Gray 2001). Perhaps the social origins of AIDS can be tackled by "reforming" economic growth through existing social and financial institutions.

## Endnotes

<sup>1</sup> I use *modernization* here because it is the word selected by the author in the original paper. Still, I believe that the concept overlaps positively with the concept of development, which I have used in the rest of this paper and, therefore, I have not altered the original word.

<sup>2</sup> Financial, health, educational, etc.

<sup>3</sup> From 1988 to 1998, when AIDS became a generalized epidemic, 30 percent of the total population of the region was malnourished, and calorie intake per capita was only 70 percent of the consumption in industrialized countries.

<sup>4</sup> Public spending on health services in Sweden is about \$1,300 per person per year; in Malawi it is about \$22 per person per year.

<sup>5</sup> The real annual income of the average person in the United States is 42 times that of the average Tanzanian.

<sup>6</sup> According to Carpenter (2000), this principle is applicable both between regions and countries and within countries themselves.

<sup>7</sup> As it follows, trade routes are the highest infection areas in Sub-Saharan Africa (Webb 1997). This association was well connoted in Stillwaggon's expression "viral traffic" (2002).

<sup>8</sup> Southern Africa had the highest rate of urbanization in the world between 1970 and 1990 (Stillwaggon 2002).

<sup>9</sup> Including Asia, Africa and Latin America.

<sup>10</sup> It was not significant in the regression using the UNAIDS measure of HIV prevalence, but significant if prevalence was measured by urban, low-risk data.

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## Appendix

Table 1

Country	Adult HIV prevalence rate, 1999 (in percent)	People living with HIV/AIDS, 1999 (in thousands)
Botswana	35.8	290
Swaziland	25.3	130
Zimbabwe	25.1	1,500
Lesotho	23.6	240
Zambia	20.0	870
South Africa	19.9	4,200
Namibia	19.5	160
Malawi	16.0	800
Mozambique	13.2	1,200
Uganda	8.3	820
Tanzania	8.1	1,300
Southern Africa	18.0	11,310
Sub-Saharan Africa	8.6	24,500
<b>Global Total*</b>	<b>0.2</b>	<b>9,800</b>

\*excluding Sub-Saharan Africa

Source: UNAIDS 2000, in Haacker 2000

Estimated AIDS deaths, 1999	Total Population, 1999 <i>(in thousands)</i>	Country
24,000	1,592	Botswana
7,100	981	Swaziland
160,000	11,509	Zimbabwe
16,000	2,108	Lesotho
99,000	8,974	Zambia
250,000	39,796	South Africa
18,000	1,689	Namibia
70,000	10,674	Malawi
98,000	19,222	Mozambique
110,000	21,209	Uganda
140,000	32,799	Tanzania
992,000	96,545	Southern Africa
2,200,000	596,272	Sub-Saharan Africa
<b>600,000</b>	<b>5,362,577</b>	<b>Global Total*</b>

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