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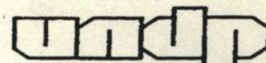

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Progress in the Social Sectors in Eastern and Southern Africa in the 1990s: A UNICEF Perspective

UNICEF Eastern and Southern Africa Regional Office

Summary

In the face of increasing poverty in Eastern and Southern Africa, it is not surprising that social sector progress has not been significant in general in the sub-region in the 1990s. The HIV/AIDS pandemic, which is increasingly a contributor to poverty, has become the single most important impediment to social sector progress in many countries of Eastern and Southern Africa, and it will continue to cause an enormous burden on and deterioration of basic services in the coming years. The effects of civil conflict obviously continue to be devastating to social sector progress in some countries.

Health services have suffered particularly from HIV/AIDS as they are overwhelmed by care of AIDS sufferers and impeded in their response due to mortality among health workers. Investment in basic health services by governments in the sub-region remains very low. The health sector gains of recent decades, particularly in child survival, are being rapidly and effectively erased by HIV/AIDS.

The education sector has seen progress in some countries, particularly in primary enrolment rates and enrolment of girls. Nonetheless, 20 million primary school-aged children in the sub-region are out of school, a number that will be multiplied by millions of AIDS orphans in the coming years in many countries as children from families affected by AIDS are the last likely to be able to afford schooling. This is already an education sector crisis in some countries and a crisis in the making in others.

There is an obvious and urgent need to break the conspiracy of silence around HIV/AIDS that in some countries still impedes strategic investment and policy development to curb the pandemic. Social sector investment, especially investment in welfare programmes that may have the chance of mitigating the social disaster caused by HIV/AIDS, must be increased. This must be a top priority of governments, international agencies and bilateral donors alike. Crisis prevention and emergency preparedness also merit greater investment by all partners. Debt relief is clearly called for in many countries as servicing debt outstrips social sector investment by far on average. Greater support to the collection and analysis of social sector data, including disaggregated data on HIV/AIDS prevalence, is urgently needed.

Introduction

1. The severe and increasing poverty of Eastern and Southern Africa described in the background document to this conference creates an urgent need for access to basic social services for all persons, but especially for children and women who are particularly affected by poverty's worst consequences. There is widespread agreement that investment in basic social services is a key to ensuring sustainable human development. There is, moreover, increasing recognition of access to basic services as a human right. And yet, progress in ensuring access to basic services of good quality has been modest and scattered in Eastern and Southern Africa since mid-decade, while setbacks have been many. This paper summarises some aspects of that progress with particular attention to health, nutrition and education and to the social sector goals noted in the background documents.

2. Some points about data and the scope of this paper are in order. (1) It would be illuminating to have trend data on key social sector indicators since 1995, the year of the Social Summit, but on many indicators this is simply not possible. Indeed, as will be argued here, greater attention to and investment in collection and strategic use of social data are sorely needed in Eastern and Southern Africa. (2) The discussion here by sector is an organisational convenience and is not meant to deny the clear and close relationship among sectors or the importance of intersectoral approaches. (3) The data referred to in general are based on the countries included in UNICEF's Eastern and Southern Africa region, which includes the countries noted in Tables 1 and 2.

Mortality and Life Expectancy

3. The infant mortality rate (IMR) and under-five mortality rate (U5MR) reflect a host of social, economic and basic service-related factors and in turn influence greatly life expectancy at birth. In the 1980s, countries of the sub-region on average enjoyed a significant decline in IMR and U5MR as public sector and donor efforts were focused on a well defined set of child survival programmes, including immunization, use of oral rehydration therapy to reduce diarrhoea-related mortality, promotion of breastfeeding, and others. Since the mid-1990s, however, infant and child mortality have taken a cruel turn upward, due in large part to the impact of HIV/AIDS. The recent Demographic and Health Survey in Kenya, for example, notes that child mortality increased by about 40 percent during the period between the late 1980s and the mid-1990s and is continuing to worsen. Similarly, in Zambia U5MR has been shown to have increased from 122 per 1000 live births to 202 from 1990 to 1997 (Table 1). In Botswana, it is projected that U5MR will rise from 45 per 1000 live births in 1991, one of the most favourable rates in the sub-region, to 148 per 1000 in 2010 with a corresponding decline in life expectancy from 67 to 52 years, off-setting the gains of social sector investments of various kinds. UNAIDS predicts that by 2005, Namibia's IMR will be 72 per 1000 as opposed to the level of 45 per 1000 that might have been expected without the impact of AIDS.

4. HIV/AIDS in Eastern and Southern Africa is thus a demographic crisis of staggering proportions. It is efficiently and comprehensively erasing the gains associated with the child survival efforts and other development programmes of governments and their partners, and its impact cannot be overstated. Of the 3 million infants infected with HIV since the beginning of the pandemic, about 90 percent have been born in Africa, the great majority in Eastern and Southern Africa. UNAIDS predicts that by the year 2010, unless urgent measures are taken, AIDS may increase U5MR by over 100 percent in at least 8 countries of the sub-region.

5. Since early in the decade, life expectancy has decreased in Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe, with HIV/AIDS certainly a major determinant of this unfortunate trend.

(Life expectancy also decreased in Rwanda since 1995, but there the effects of civil conflict are probably predominant.) Over 20 percent of pregnant women are estimated to be HIV-positive in these countries -- over 40% in Botswana -- and until primary prevention among young people is able to reverse these rates, it is difficult to see how mortality trends will improve. The child mortality figures shown in Table 2 do not yet reflect this impact in all countries because some have not surveyed child mortality since the beginning of the decade, but the Zambia figures and the very recent Kenya survey very likely reflect results to come.

Health and Nutrition

6. Public sector investment in health and nutrition remains very low in the sub-region relative to the magnitude of the problems faced. Of the 15 countries in Eastern and Southern Africa for which data are reported in the recently released *World Development Report 1998-99* of the World Bank, the average public sector expenditure on health as a percentage of GNP was 2.5, and no country's expenditure was higher than 4.6 percent of GNP.

7. HIV/AIDS has transformed this sector for the worse. Care of AIDS sufferers has overwhelmed health services in many parts of the sub-region while capacities have been decimated through AIDS-related mortality among health workers. It is, again, impossible to overstate the negative impact of HIV/AIDS on health services and deterioration of the health sector in the sub-region since 1995.

8. It is worth remembering that HIV/AIDS is increasingly cited as an example of public health triumph in the wealthy countries of Europe and North America. Drug therapies have prolonged life and improved the quality of life of persons with AIDS, and the terrible phenomenon of mother-to-child transmission (MTCT) of HIV is under control. But these medical miracles remain well out of reach in Eastern and Southern Africa. The demonstration in early 1998 of a breakthrough short-course treatment of the anti-retroviral drug AZT that drastically reduces MTCT holds out the promise for some reduction of vertical transmission in several countries of the sub-region in the coming year or two. This is partly because the manufacturer of AZT has indicated that they drug may become available in the region for less than $50 for the recommended treatment in late pregnancy, though this will still be too costly for some communities. But in many countries the required HIV testing and counseling services needed to implement the AZT short course are inadequate to ensure its widespread use. And certainly the costly "cocktail" drugs that are prolonging life in the wealthy world will remain unaffordable. This situation of gross inequity should be viewed, among other things, as a challenge to private-sector drug manufacturers to demonstrate their concern for persons with AIDS by making drugs available at affordable prices to countries in the sub-region.

9. Primary prevention of HIV/AIDS especially involving behaviour change among young people remains the best hope for the sub-region. Uganda's work in primary prevention is frequently cited as the success in the region, and there is much still to be learned from this case about the causation of the decline in transmission experienced in some communities. One obvious lesson seems to be that primary prevention will not succeed without breaking the conspiracy of silence that continues in some countries to impede open discussion and recognition of the HIV/AIDS problem, its determinants, and its devastating impact.

10. Whether related HIV/AIDS, the general increase in poverty and income disparities, or other factors, health services and goals have failed to show much progress since 1995 in the sub-region. Access to basic services remains limited for too many. The Bamako Initiative reforms involving cost recovery and community-based control that have increased access to services in many West African countries have generally not taken as strong hold in Eastern and Southern Africa. Studies on the introduction of user charges in such countries as Kenya and Zimbabwe have shown that user fees discourage the use of services among some needy segments of the population, and safety nets and other special measures to ensure access of services by poor households remain unimplemented. In some countries -- notably Zambia, Tanzania, Kenya, Uganda and Namibia -- rates of immunization coverage have been difficult to sustain at the levels reached in the 1980s. The WHO/UNICEF initiative on Integrated Management of Childhood Illness has

begun since 1997 to improve efficiency of services delivered with each visit of a child to a health facility. It is also beginning to support measures to be taken in the community and household to improve children's chances of survival and development. But these measures cannot compensate for poor access to basic services in many parts of the sub-region.

11. Malaria remains a major killer of children in the sub-region, and also of women, especially primiparous women, due to the severe anaemia it causes, which greatly elevates the risk of death in childbirth. Malawi is one of the few countries in the region that has invested in a revamping of drug protocols to take into account resistance to chloroquine and to institutionalise the use of other drugs. Similar efforts are badly needed in other countries. A number of projects promoting the use of insecticide-treated bednets, notably in Kenya, Zambia and Botswana, have shown that both child and maternal mortality can be greatly reduced by the their regular use in malaria-endemic areas. Use of bednets has been impeded in some countries by tariff policies that classify bednets as textiles and assess large luxury taxes on their importation. Changing such policies is another urgent need. The IMCI Programme through its training of health workers and community-based promotion of bednet use, can be a mechanism for improving the response to malaria in the sub-region. There are currently WHO, UNICEF and World Bank initiatives to address malaria in Eastern and Southern Africa, and care will be needed to ensure good coordination of these.

12. Maternal mortality and more generally mortality of women in the reproductive years is a grave problem in Eastern and Southern Africa. Tanzania and Malawi are among the few countries that have taken important initiatives to try to document the magnitude and causes of women's deaths through very decentralised monitoring systems, an important first step. In many countries, the extent of the problem is not even well understood. It is clear, however, that addressing the problem will require strategic involvement of communities and health services in ensuring access of all women to obstetric care as well as improving antenatal care, including access to nutrient supplements. Recent studies have shown that in malaria-endemic areas, presumptive treatment of all pregnant women with two doses of Fansidar during pregnancy can significantly reduce maternal death. This protocol is being considered as policy in a few countries. HIV/AIDS obviously also makes an important contribution to women's mortality in the sub-region and must be accounted for in the development of maternal mortality strategies.

13. One success in the health sector in Eastern and Southern Africa since 1995 has been the implementation of national immunization days (NIDs) as part of the global effort to eradicate polio. Virtually all countries in the sub-region have had NIDs that have reached over 80% of all young children, and most have included distribution of high-dose vitamin A supplements. The unfortunate decision this year in Kenya not to include vitamin A with the NID is happily an exception in the sub-region. If given about twice a year, vitamin A supplements have the potential to reduce U5MR by as much as 25% among vitamin A-deficiency children. The high coverage of NIDs has plainly meant that many children otherwise unreached by regular health services have been reached with polio vaccine and vitamin A in the last two years.

14. Vitamin A supplementation coverage is estimated to have risen from about 24 percent of children under age 2 in 1996 to over 60 percent in 1998, largely thanks to NIDs. Some caution in interpreting this increase is required, however. Since NIDs happen only once a year, one other occasion per year for reaching children with vitamin A needs to be found for the life-saving benefits of this supplementation to be enjoyed. Some countries, such as Ethiopia, have instituted "micronutrient days" or other such occasions for ensuring adequate frequency of supplementation. Boosted by the success of the NID campaigns, Malawi now also administers measles immunization as a campaign-style national day. Other countries are exploring the use of campaign approaches for improving coverage of immunization, vitamin A supplementation, deworming, redipping of bednets, and other such services. It remains to be seen how sustainable these campaign approaches will be, particularly when the considerable donor support to polio eradication diminishes, and also what influence they will have on utilisation of regular health services.

15. Child malnutrition, like mortality, has not been very frequently surveyed in the sub-region. Recent anthropometric surveys indicate that little progress has been made in reducing malnutrition since mid-decade. There is good evidence to suggest that nutritional status has been deteriorating since mid-decade

in Angola, Burundi, Ethiopia, Eritrea, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Zambia and Zimbabwe. This may be expected as poverty worsens in some of these countries; the impact of HIV/AIDS as well as of conflict and political instability is clearly evident here as well. The sub-regional average of about 30 percent of pre-school children underweight remains unacceptably high. The new science of early child care for development, highlighting the importance of child stimulation and good child feeding for very young children, has failed to be captured in programmes but is beginning to be considered as part of IMCI in several countries in the sub-region.

16. The more straightforward goal of iodising salt to eliminate iodine deficiency as a public health problem in the region has enjoyed considerable success during the decade. The few countries in which less than 50 percent of salt is iodised are poised to make gains in the coming year or two. The Ethiopia-Eritrea tensions have had the unfortunate side effect of cutting off the Ethiopian population from iodised salt produced in Eritrea, and other means are being sought to ensure its availability. Salt iodisation legislation is still pending in those two countries as well as in Botswana and Mozambique, though access to iodised salt is quite good in the latter two countries.

17. The promotion, protection and support of breastfeeding were generally a great step forward for child survival in the sub-region in the 1980s and early 1990s, and these gains too are unfortunately at risk of being compromised by HIV/AIDS. The fear of passing HIV to an infant in breastmilk may be driving many women, including many HIV-negative women, to choose artificial feeding when otherwise they would have breastfed. It is essential the HIV testing services become more widely available and affordable for all people, including pregnant women, as well as appropriate and well informed counseling about infant feeding options for HIV-positive women.

Education

18. There is a well established international consensus that primary education, especially education that includes girls on a par with boys, is arguably the best investment a government can make to ensure sustainable human and economic development. Nonetheless, investment in primary education remains uneven among governments in Eastern and Souther Africa. Public expenditure on education as a percentage of GNP is 5 percent or less in Madagascar, Uganda, Zambia, Burundi, Lesotho and Tanzania and less than 9 percent in the remaining countries for which data are available -- Swaziland, Kenya, South Africa, Zimbabwe, Botswana and Namibia. In some countries, a high proportion of this expenditure is allocated to higher education from which lower-income households are unlikely to benefit.

19. Relatively few countries in the sub-region have net primary enrolment data that enable trends to be calculated since mid-decade. Of those for which data were reported in 1990 and in 1996, four countries (Comoros, Lesotho, Botswana and Mauritius) demonstrate approximately status trends in this period, most of the large countries in the region show somewhat increasing trends, and five countries, including Mozambique, Kenya, Swaziland, Rwanda and Burundi, have experienced declines (see Table 2). Once again, the devastating effect of armed conflict on basic services is evident in these trends. In Kenya, the increase in poverty has clearly contributed to the inability of households to pay for schooling. There is an urgent need for countries to collect regularly gender-disaggregated data on net enrolment for progress in the education sector to be assessed.

20. Countries in Eastern and Southern Africa have made generally good progress in meeting the goal of gender equity in primary school enrolment. Only in Mozambique, Angola , Ethiopia, Eritrea (all low enrolment countries), and to a lesser extent Zambia are the gross and net enrolment of girls significantly lower than those of boys. In the unusual case of Lesotho, where many boys are employed as herders from a young age, girls have significantly higher primary school enrolment than boys. As noted in Table 2, there are still several countries that do not have net primary enrolment data disaggregated by sex. The African Girls' Education Initiative, an important programme that assists 13 countries in the sub-region as well as a number in West and Central Africa, is enabling some countries to accelerate action in this area. In

Eritrea, for example, AGEI is enabling more rapid training of women teachers; the presence of women in the classroom has been shown in many countries to be closely associated with girls' enrolment and retention rates.

21. Overall primary enrolment of girls is not, however, the end of the story. Girls have generally higher drop-out rates, particularly in the late primary years as the value of their labour outside school increases. The educational achievement aspirations of girls remain low in many countries, to say nothing of low expectations of teachers and parents. In the few countries where learning performance has been assessed, girls consistently are shown to perform worse than boys (with the exception of Mauritius and Madagascar). Initiatives such as AGEI must address gender equity on all these fronts beyond enrolment.

Table 2: Percent primary school net enrolment rate NER by sex and public expenditure on education (Source: UNICEF ESARO, 1998; data for some countries unavailable)

Country	Total NER (%)	NER, boys (%)	NER, girls (%)	Public expenditure on educ. as % of GNP
Ethiopia	21	25	16	
Eritrea	29	30	28	
Burundi	30	32	27	3.8
Mozambique	36	40	32	
Sao Tome	36	40	32	
Angola	39	49	31	
Comoros	55	57	55	
Tanzania	55	54	55	5.0
Rwanda	56			
Madagascar	65	64	65	1.9
Lesotho	67	62	72	4.8
Kenya	72			6.8
Swaziland	80	79	80	6.8
Zambia	81	85	77	2.6
Malawi	83	83	83	
Uganda	84	86	82	2.0
Zimbabwe	86			8.3
South Africa	94	95	93	7.1
Namibia	95	93	98	8.7
Botswana	96	95	97	8.5
Mauritius	99	98	99	
Seychelles	100	100	100	7.4

22. An important recent development in the region has been the adoption in Malawi in 1994 and in Uganda in 1997 of a policy in favour of universal free primary education. In Malawi, this policy resulted in a rapid increase in primary school enrolment from 1.9 million to about 3.2 million. In Uganda, it seems to be having a similar effect, though it is too early to measure the full impact. Donors have responded

enthusiastically to the decision in Malawi, enabling the government to sustain this commitment and ensure the building of new classrooms, purchase of additional supplies, and training of teachers that are needed to support the higher enrolments.

23. The education sector in Eastern and Southern Africa has of course not been immune from the devastating impact of HIV/AIDS. Many teachers have been lost to the pandemic. Ensuring access to schooling of AIDS orphans and other children whose families are affected by HIV/AIDS is proving to be a major challenge in many countries and constitutes a looming social crisis throughout the sub-region. There are currently 8.2 million AIDS orphans in the world of which 90 percent are in sub-Saharan Africa and 70 percent of these in Eastern and Southern Africa. These numbers will multiply in the coming years. These children are unlikely to have the support they need to pay school fees, to say nothing of other elements of a supportive environment. In this regard, the free education policies of Malawi and Uganda are particularly important.

24. HIV/AIDS and overall increasing poverty will contribute significantly to the numbers of children out of school, which are already very high in the sub-region. Ethiopia, Kenya, Mozambique, Tanzania, Angola, Somalia and Madagascar account for more than 16 of the 20 million children of primary school age who are out of school, with Ethiopia having by far the largest total. Uganda is addressing the problem of children out of school through an innovative programme called Complementary Opportunity for Primary Education (COPE), which offers accelerated primary courses for overage children. A similar programme called COBET is under way in Tanzania.

25. Equity in access to education should remain a top policy and programme priority in Eastern and Southern Africa. As was recently noted by President Nelson Mandela during a state visit to Tanzania, the educational system has in too many countries of the sub-region become the principal mechanism for the maintenance of inequitable class differentiation -- increasingly it is only the relatively rich who enjoy the benefits of education, thus perpetuating the marginalisation of the poor. The policies of universal access to some minimum quality of education that were frequently seen in the 1960s in some countries of Eastern and Southern Africa seem to have vanished. This is a continuing advocacy and policy challenge in the sub-region.

Water and Sanitation

26. Regular access to safe water is one of the areas in which on average there have been significant gains in Eastern and Southern Africa in the 1990s. Overall, UNICEF estimates that the average percentage of the population in the region with regular access to safe water has risen from about 37 percent in the late 1980s to about 52 percent by 1997. The regional average masks a great variety of experiences, and within countries, rural populations are frequently heavily disadvantaged in access to water and sanitation facilities compared to urban communities. Much remains to be done, of course, to increase access to water for all persons in the sub-region and to safeguard the gains made so far. A number of countries in the sub-region remain vulnerable to periodic droughts, and effective management of water resources will be essential to avert disaster in the coming years.

20/20 and the Prospects for Social Sector Investment

27. The 20/20 Initiative, endorsed by the Social Summit in 1995, calls for the allocation of at least 20 percent of national budgets and 20 percent of official development assistance (ODA) to spending in the basic social services in most countries. According to evidence presented at the recent follow-up meeting in Hanoi on implementation of 20/20, Namibia and Uganda are among the few countries in the sub-region that have allocated at least 20 percent of public expenditure to basic social services. In both cases, social sector allocations have enjoyed rapid growth only quite recently, and it is therefore difficult to assess the impact of this policy choice.

28. Social service expenditure by the government was reported to be in decline in Kenya in recent years, currently at about 12.6 percent. In virtually all countries for which detailed studies were done, the lion's share of the social services budget goes to education. In the case of Kenya, an estimated 40 percent of the national budget goes to services external debt. Zambia was reported to have a similar allocation to debt payments, with only 6.7 percent of the national budget allocated to basic social services. Tanzania devotes 46 percent of its national budget to debt service and 15 percent to basic social services. Over 20 percent of ODA to Kenya and Namibia is in the basic social services. For Uganda, the figure is 16 percent, Tanzania 10 percent and for Zambia 13 percent.

29. It is difficult to imagine that current patterns of national budget and ODA allocations ti basic services will be sufficient to improve access services in general and even less to address the looming social service crisis represented by HIV/AIDS. Not only will HIV/AIDS cause increased demand for health services, AIDS orphans are already straining existing social service systems, and this will only get worse. In Zambia alone, it is projected that there will be 1 million AIDS orphans in the next 10 years. A UNICEF estimate suggests that by 2010, over 35 percent of children under age 15 in Botswana, Malawi, Zambia and Zimbabwe and very high percentages in South Africa and Malawi will have lost one or both of their parents to AIDS. The threat to economic and social stability as well as human development that these figures represent is staggering.

Conclusions and Recommendations

30. Some conclusions and recommendations emerge from this discussion:

1. **Bringing the HIV epidemic under control:** HIV/AIDS is erasing the social sector gains in many countries of Eastern and Southern Africa through its mortality impact in productive adults, its creation of AIDS orphans who represent an important social sector responsibility for the sub-region in the coming years, and its continuing contribution to poverty. The struggle against HIV/AIDS must be put on a more urgent footing by all governments and their partners. It is clear that there is no one formula for ensuring success of primary prevention efforts. Communities must be part of discovering the behaviour change and advocacy efforts that succeed best for them. Community-based programmes require considerable investment and care in implementation, monitoring and evaluation. Governments, international agencies, bilateral donors and civil society organizations must all make the fight against AIDS the equivalent of a military campaign for the current dire situation to be turned around. In particular, the conspiracy of silence and denial about HIV/AIDS as a social crisis must be broken. Without this, the application of lessons and best practices and strategic investment to address HIV/AIDS will be impossible.

2. **Social service investment and safety nets:** There is a profound and urgent need for greater to address the continuing and worsening social crisis of HIV/AIDS and AIDS orphans. There is good evidence to suggest that even in very low-income countries, strategic investments can enable social safety nets and social welfare services to be put in place. Targeted food supplementation programmes in Botswana, Zimbabwe, Lesotho and Zambia are examples. The principles of the 20/20 Initiative should be adopted and implemented in all countries.

3. **Debt:** As Carol Bellamy, Executive Director of UNICEF, recently noted, the phenomenon of debt service far outstripping investment in basic social services as percentage of government expenditure is "morally unacceptable and economically senseless". Removal of the debt burden in many countries in the sub-region is an urgent priority. The fiscal

dividend resulting from debt relief can be earmarked for basic services, which would go a long way to renewing the survival and development chances of thousands of children in Eastern and Southern Africa. The recent Hanoi meeting on 20/20 echoed this sentiment, calling for "additional efforts to grant early and deep debt relief and forgiveness in favor of the allocation of extra resources to basic social services".

4. **Emergency preparedness and prevention of crisis:** The persistence of complex emergencies related to civil conflict as well as natural disasters in the sub-region continue to undermine progress in the social sectors. It is facile but necessary to note that resolution if conflict should be high priority in the sub-region and would have immediate and far-reaching social sector benefits. Greater investment in emergency preparedness and special attention to the protection of women and children in crises and would also have inestimable benefits. Governments and donors alike should regard investment in conflict resolution and emergency preparedness as high priorities for social spending.

5. **Use of data:** Collection and analysis of basic social are data in many countries in ESA remain low priorities. Design, targeting and implementation of strategic social sector investment are handicapped by this lack of hard information. Determining progress on a number of basic indicators is also impossible in too many countries. Data on the prevalence and transmission of HIV/AIDS that can be disaggregated to the district and even more decentralised levels would be a powerful tool.

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Tableau 1 : Indicateurs démographiques et de base : Evolution depuis 1990

	TMM5 mondial		TMM5		M5 Pop.(x 1000) Ms		Total Pop.(x 1000) Total		Naissances		Esp. vie à la naissance		% pop.ay accès à l'eau potale	
	1990	1997	1990	1997	1990	1997	1990	1997	1990	1997	1990	1997	1988-1990	1990-1997
1. Angola	3	2	292	292	1800	2250	10000	11569	472	556	45,5	47	35	31
2. Botswana	60	80	1 85	49	300	240	1300	1518	61	53	59,8	51	54	90
3. Burundi	18	17-	192	176	1000	1145	5500	6398	261	274	48,5	47	38	52
4. Comores	5*	39	1 151	93		115	551	651	26	26	55,0	57	-	53
5. Erythrée	-	41	-	116		584	-	3409	-	137	-	51	-	22
6. Ethiopie	11	16	1 220	175	9300	11663	49200	60148	2424	2936	45,5	50	19	25
7. Kenya	49	55	1 108	112	4700	4497	24000	28414	1132	1054	59,7	54	49	53
8. Lesotho	43	32	129	137	300	332	1800	2131	72	75	57,3	59	48	62
9. Madagascar	24	21	176	158	2200	2823	12000	15845	547	656	54,5	58	22	26
10. Malawi	6	8	1 253	215	1800	1897	8800	10086	494	488	48,1	41	56	47
11. Maurice	93	123	1 28	23	100	111	1100	1141	19	22	69,6	71	95	98
12. Mozambique	1	9	1 297	208	2800	3250	15700	18265	699	777	47,5	47	24	63
13. Namibie	28	60	1 167	75	300	256	1800	1613	76	58	57,5	56	-	83
14. Rwanda	16	19	1 198	170	1500	1025	7200	5883	368	267	49,5	40	50	79
15. Sao Tomé et Principe	12*	57	55	78		26	121	138	4	6	65,5	64	-	82
16. Seychelles	32*	136	21	18		14	69	75	2	3	70,0	71	-	-
17. Somalie	13	10	215	211	1400	2027	7500	10217	360	519	46,1	49	37	26
18. Afrique du Sud	54	69	1 88	65	4900	5854	35300	43336	1108	1295	61,7	65	-	87
19. Swaziland	3*	53	1 167	94		147	789	906	37	33	56,8	60	-	50
20. Tanzanie	26	29	1 170	143	5600	5568	27300	31507	1387	1303	54,0	51	56	66
21. Ouganda	31	30	164	137	3900	4198	18800	20791	985	1070	52,0	41	21	46
22. Zambie	44	13	122	202	1800	1508	8500	8478	433	361	54,4	43	60	38
23. Zimbabwe	57	65	1 87	80	1700	1967	9700	11682	399	437	59,6	49	66	79
Région			13		47390	52608	247030	294201	11366	12269	53	52	37	52