A Preliminary Study of the Socio-Economic Impact of HIV/AIDS in Africa

Theresa M. Ndongko*

Résumé: *L'article présente une étude préliminaire de l'impact socio-économique du SIDA/VIH en Afrique. Examinant l'évolution générale de la propagation de la pandémie et son impact sur les différents aspects de la vie économique et sociale, l'auteur démontre que les réponses nationales et locales au niveau des pays africains, bien qu'elles constituent un début, n'en demandent pas moins beaucoup d'attention et de moyens. L'auteur termine son article en suggérant ce qu'il est possible de faire à tous niveaux pour la prise en charge de la pandémie.*

Introduction

HIV/AIDS is an epidemic that is reaching phenomenal proportions in Africa. By the end of 1991, more than 850,000 people in Africa had died from AIDS. Out of this number, 200,000 died during 1991 only. The World Health Organization (WHO) estimates that close to 9 million Africans, are currently infected with the HIV virus (African Bank Group 1993a:5), another 1.200.000 have already died from full blown AIDS (African Bank Group 1993a:6), and that cumulative deaths will reach 5.5 millions by the end of the year 2000 (Kambou *et al.* 1992:112). The WHO Global Programme on AIDS (WHO/GPA) however estimates that the true number of cases may be ten times larger due to under-reporting.

Within Sub-Saharan Africa, HIV infection is unevenly distributed across geographic areas, age groups and socio-economic classes. The percentage of the population infected with HIV ranges from less than 1% across most of the continent to more than 50% in certain sub-regions. The most seriously affected countries are those roughly clustered around Lake Victoria. They include Rwanda, Uganda, Burundi, Tanzania, Kenya, Malawi, Zaire, Central African Republic and Congo.

In spite of the general belief that many more women than men in Africa are infected by HIV/AIDS, Kambou *et al.* (1992:113) argued that in Africa 'AIDS cases are almost evenly divided among men and women, reflecting the fact that heterosexual intercourse is the principal transmission mechanism for HIV'. Most of the infection occurs, however, among the most economically active groups of adults, especially those aged between 15 and 44 years. Again there is recent evidence that the prevalence rate of HIV

Africa Development Vol. XXI, No. 1, 1996, pp.39-55

infection is highest in the more advanced social classes. For example, a study of seroprevelance in a large textile factory in Kinshasa (Zaire), revealed that HIV infection rate for executives was 5.3% as against 4.6% for foremen and almost double the 2.8% rate for workers (Over 1992:58). For the estimates of HIV-1 sero-prevalence see Table 1.

A national survey of HIV cases in Rwanda revealed an infection rate of 30% among urban adults with more than primary schooling as against the 20.8% rate for those with less schooling. On the other hand, a 1991 sample of Zambian hospital patients found progressively higher infection rates among patients with greater schooling, from 8.0%. Studies confirm the view that the epidemic is striking disproportionately the groups with the highest level of productive skills and human capital. (Whether this is because they are more affected, or because they have better access to health services and therefore are counted, is not yet clear). From the foregoing analysis, it is clear that HIV/AIDS is 100% fatal, kills adults in their economically most productive years and knows no social class boundaries. Consequently it has a tremendous socio-economic impact on the society, particularly as it lowers life expectancy and increases mortality rates.

Impact of HIV/AIDS on Households

At the household level, where fundamental economic decisions are made, HIV/AIDS strips families of their main sources of financial and non-financial support. For the affected individuals, the consequences include the psychological and emotional distress caused by illness and death, a critical need to care for those infected and to find ways of replacing their contributions to the household and the community, a decrease of labour productivity resulting in loss of income and food, reduced support for the elderly, as adult children die, and a growing burden of orphans is left on the extended family and other concerned friends, and as a result, the coping mechanisms have come under severe strain. Besides, more time and money are generally spent on the AIDS patients there by reducing not only the time which adult caretakers would have spent working but the disease also reduces family consumption and savings. On the other hand, many family members most frequently without remunerations may feel pressured to give up work entirely and as a result, the difficulty of being financially dependent on some one else arises.

Table 1: Estimates of HIV-I, Sero-prevalence by Residence and Risk Factor for Selected African Countries : HIV Sero-prevalence (%)

Country	Cities	Rural	High Risk
Benin	0.1	6.7	4.5
Botswana	0.8	0.1	1.2
Angola	1.3	-	14.2
Burkina Faso	1.7		18.5
Burundi	17.5	-	18.5
Cameroon	1.1	0.4	8.6
Cape Verde	1.1	0.4	8.6
Central Afr. Rep.	7.4	3.7	20.6
Congo	3.9	1.0	34.3
Côte d'Ivoire	8.5	3.3	23.8
Djibouti	0.3	0.0	2.7
Equatorial Guinea	0.3	0.3	-
Ethiopia	2.0	0.0	18.2
Gabon	1.8	0.8	-
Gambia	0.1	-	1.7
Ghana	2.2	-	25.2
Guinea	0.6	0.2	-
Guinea Bissau	0.1	0.0	0.0
Kenya	7.8	1.0	59.2
Malawi	23.3	-	55.9
Mali	0.4	-	0.0
Morocco	0.0	-	7.1
Mozambique	1.1	0.8	2.6
Nigeria	0.5	0.0	1.7
Rwanda	30.3	1.7	79.8
Senegal	0.02	0.0	2.3
Sierra Leone	3.6	-	2.7
Somalia	0.0	-	0.4
South Africa	0.1	-	3.2
Sudan	0.0	-	16.0
Tanzania	8.9	5.4	38.7
Tunisia	0.1	-	1.9
Uganda	24.3	12.3	86.0
Zaire	6.0	3.6	37.8
Zambia	24.5	13.0	54.0
Zimbabwe	3.2	1.4	-

Note: Data not available - 'High Risk': Prostitutes

Source: Kambou, G., *et al.* 'The Economic Impact of AIDS in an African country: Simulation with a Computable General Equilibrium Model of Cameroon', *Journal of African Economics*, Vol.1, No.1, 1992.

As observed by Ainsworth, evidence indicates that households in Africa spend heavily on medical care for AIDS patients. For example, Davachi *et al.* estimated that one 25 day episode of in patient treatment for a paediatric AIDS case at Mama Yemo Hospital in Kinshasa Zaire, costs the households $90 being three times the average monthly income (Ainsworth 1993:4). A subsequent study in the same hospital found that prior to admission, HIV-positive patients had spent $109 on medical treatment compared with half that amount among HIV negative patients (Ainsworth 1993:5). And greater spending on caring for the person with AIDS may mean that less is available for the health care of other family members. Apart from this, when the patient dies, the household does not only lose his/her time and skills but may also lose access to land, housing and other assets which he or she might have acquired. Such a death does generally result to reduced schooling and higher child malnutrition. For example, a household survey in central Kampala revealed that of the families with orphans, 47% reported not having enough money to send children to school compared with 10% of families with no orphans (Hunter 1990:681-690).

Furthermore, if a family should experience a death resulting from HIV/AIDS infection, then widows or widowers and orphaned children are left with little income and high funeral expenses. In Africa, funeral expenses are sometimes higher than medical costs. For example, in Zaire, the average out of pocket costs of funeral and wake for a paediatric AIDS death in Kinshasa has been estimated at $320 which is equivalent to 11 months income and several times greater than the cost of a 25 day hospital admission for treatment (Davachi *et al.* 1988).

Similarly, in Southern Zambia, a basic coffin can be bought for about $66 but it is common for a house hold to spend about $200 or more. According to the law, all persons who die in the towns must be transported to the mortuary. In addition, the family must arrange for transportation, food and accommodation of mourners. These certainly are additional major expenses for the surviving family members.

WHO predicts that by the year 2000, over 10 million HIV — negative children under age 10 will be in Sub-Saharan African (African Bank Group 1993a:64). However, children, themselves will not escape this epidemic. According to UNICEF, due to HIV/AIDS, the under — 5 mortality rates in Central and Eastern Africa will rise from 159 to 189/1000 rather than fall to 132/1000 as previously expected (African Bank Group 1993a:69). In Rwanda for example, children account for one of every five AIDS cases while in Zambia it was estimated that in 1988, 6,000 babies were to be born with HIV/AIDS infection (Oyekanmi 1994:159). Discussing the impact of HIV/AIDS on African children, Preble (1990:671-680) also revealed that in ten Central and Eastern African countries paedriatic HIV infection and AIDS are the major causes of child morbidity and mortality. It is expected

that in these countries AIDS and HIV infection will cause a quarter to half a million child deaths annually increasing the under-five mortality rate (Preble 1990:675). In addition, current reported increases in adult deaths from AIDS are creating a large number of children under the age of 15 who have lost their mothers to AIDS. It is estimated that during the 1990S, AIDS will kill a total of 1.5-2.9 million women of reproductive age in the region, leaving 3.1-5.5 million orphans (Preble 1990:675).

This has serious implications. Firstly AIDS orphans will exhaust all forms of long-term child care services which are in themselves limited. Secondly, placing orphans poses a number of problems, namely they may be adopted by relatives and this may result in less care and neglect of health, education and nutritional needs of orphans which represent several steps back in development and possibilities for the children. Apart from this, orphanages which could provide a quick and lasting solution are very rare in Africa and where they are available, they are often poorly equipped and staffed. Some of the time, these orphan children are simply abandoned on the streets and as a result, they become vulnerable to HIV infection as they exchange sex for food and money. At times, premature deaths due to neglect and illness is a possible outcome which explains why morbidity and mortality of orphans is higher than that of African children cared for by their mothers.

The Impact of HIV/AIDS on the Industrial Sector

Like in the case of the households, the impact of HIV/AIDS has also been quite devastating in the industrial sector. The industrial sector seems to suffer most from the AIDS epidemic because as the households, it has a considerable stock of physical and human capital in terms of physical assets, skills and experience of its work force. To the extent that the workers in the firms are increasingly HIV-positive, the workforce and its stock of skilled labour is reduced, productivity is lowered, absenteeism increases, firms experience higher turnover rates and higher training and recruitment costs. For example, researchers in South Africa, Zambia and Zimbabwe have estimated that 'absenteeism and fatigue on the job due to AIDS illness may be more costly to firms than the deaths' (Panos Institute 1992).

The firms in addition also incur greater outlays for health, unemployment, funeral and death benefits. For example, Ainsworth (1993:6) has estimated that 'as many as 10% of the Uganda Railway corporation's 5,600 employees have been lost to AIDS in recent years; producing a labour turnover rate of 15% per year and the annual hospital bill for the Corporation has risen to $3177.300' (African Bank Group 1993:7). At this rate, HIV/AIDS will certainly destroy the industrial sector which is the key development sector with many employees. Besides, many countries will become increasingly economically vulnerable since in some cases, up to

80% of their export earnings come from the industrial sector in which 30% of the managerial personnel may be HIV infected.

The adverse effects of HIV/AIDS on the work force may encourage firms to use capital — intensive rather than labour-intensive methods of production. Some may even introduce HIV-screening but that may change the criteria for promotion and for advancement from competence to the ability to remain HIV negative. This method is certainly not the best since an employee may likely contact AIDS either after his employment or advancement. Some firms on the other hand may 'recruit and train more workers than actually needed for a specific job in anticipation of some losses to AIDS' (AIDS TECH 1992) while others may be forced to employ the services of expatriate workers who are definitely more expensive than the local experts. Consequently, such a policy will lead to higher costs of production for the firms.

The impact of HIV/AIDS on the Health and Education Sectors

The health sector is also severely affected by the HIV/AIDS epidemic. HIV/AIDS patients absorb an increasingly large proportions of the hospital system's resources and take up the bed-space of patients with curable diseases. Confirming this, Burce, *et al.* (1992), revealed that in 1991, about 28% of all in patient admission and 43% of the adult bed days in a 250-bed hospital in Southern Zambia were for HIV — related illnesses. Similarly in Kenya, it is estimated that 40% of the hospital beds are occupied by HIV — positive patients (AIDS TECH 1992:27). On the other hand, WHO revealed that in some of the severely affected countries, up to 80% of the beds in several hospital wards are now occupied by patients suffering from AIDS (WHO 1992:3). The cost of care has soared in the most severely affected countries despite the fact that none of them is employing the most expensive brands of drugs for the palliative management of AIDS patients.

HIV/AIDS according to current evidence is far more expensive than any other disease; making the cost of treatment often 3 times more than the average monthly income of a Sub-Saharan African country (African Bank Group 1993a:55). Between 1987 and 1988, for example, HIV positive patients in Zaire spent between $132 and $1585 on treatment, patients in Tanzania spent $104 — $631 per case and in Zimbabwe 'expenditure per case is thought to range between $64 and $2574 with a mean expenditure of $614 depending on the cost of hospitalization' (White 1991).

In spite of the high cost of treating AIDS patients, the hospital system is increasingly loosing some of its workers to HIV/AIDS and this will certainly affect the supply of medical care. For example, a study conducted in Kinshasa Zaire in the mid 1980's revealed that 6.4% of a sample of 2,384 hospital workers at the Yemo Hospital were seropositive (Ainsworth 1993:10). On the other hand, mortality rates among nurses in two hospitals

in Southern Zambia has risen from 0.5% per year in 1980 to 2.7% in 1991; presumably due to the AIDS epidemic (Buve *et al.* 1992).

The education sector like the other sectors of the economy has not escaped the impact of the AIDS epidemic. For example, Ainsworth observed that the 'high risk of contracting HIV among the educated may lower the returns to education from the household point of view, resulting therefore, in lower schooling investment (Ainsworth 1993:10). If the spread of the epidemic is not halted, then not only will the demand for schooling drop, but the cohort size entering school will be smaller than would have been without AIDS. Besides, enrolment rates will decline while the number of drop-outs will increase because of the inability of the affected parents or surviving relatives to pay for schooling. Apart from that, children may be needed to stay home and help out with the household chores, earn a living or care for the AIDS patients.

On the other hand, HIV/AIDS will reduce the workforce in the schools. It will certainly affect the number of teachers needed, their training costs and the efficiency of the entire system. This scenario will leave some countries like Tanzania, with 14,460 teachers less by the year 2010 and 27 000 by the year 2020. Furthermore, the training of replacement teachers will cost the country about some $37.8 million (African Bank Group 1992a:63).

In view of the current economic crisis and additional problems resulting from the HIV/AIDS epidemic, the public may put undue pressure on the authorities to exempt children who have lost their parents to AIDS from paying school fees. Though human, reasonable and acceptable, such a decision may stigmatize AIDS orphans and make their integration into normal school like difficult if not impossible. On the other hand, the school system which depends largely on revenues from school fees for the payment of staff salaries and the purchase of school equipment and supplies will have to face the problem of shortages of funds.

Besides, exempting AIDS orphans from paying fees will most likely create huge financial burden for other children's families, a majority of whom are already very poor. It may simply create tension in the schools as other children considering the economic situation of their parents may argue for the same treatment.

Preventive Measures

The foregoing analysis confirms the view of the African Bank Group that HIV/AIDS is a challenge to human survival, human rights and human development. In view of the imminent danger which the epidemic poses to individuals and society, African Governments and all concerned organizations such as WHO and other UN agencies have to devise and adopt preventive policies and strategies which are likely to have an impact on the epidemic, provide resources that are needed to halt the spread of the disease,

provide support and care for people living with HIV/AIDS; their families, those caring for them and those who survive after the death of the affected family members. In addition, efforts should be made to involve all concerned groups such as local leaders, health professionals, traditional and non-governmental organizations, the private sector, trade unions, religious and political bodies, youth and women groups, etc. in the fight against HIV/AIDS.

In the absence of a vaccine, treatment or cure, the preventive measures or strategies which have been identified are those which are primarily going to promote behaviour change. Confirming this view, Dr. Merson, Director of WHO Global Programme on AIDS argued that 'There is now no doubt that even without a vaccine or cure, we can slow down this epidemic through carefully mapped out strategies (WHO 1992:2). These strategies among others include:

Sensitization Campaigns

Mass and small media communication campaigns are an important way of sensitizing and raising levels of knowledge among the population about HIV/AIDS. These campaigns if properly organised can and have led to behaviour change particularly as they do encourage interpersonal discussion of AIDS especially among couples which in fact is an important step towards protection.

A number of successful communication campaigns have been carried out in Africa firstly to sensitize the general public to the danger of HIV/AIDS and secondly to reduce the stigmatization of those suffering from AIDS. For example in Uganda and Zambia, governments' official recognition of the threat which HIV/AIDS poses to human survival has contributed to the acceleration of responses in both the public and private sectors thus creating' a suitable environment for public debate on AIDS'. In addition, the stigma attached to AIDS has reduced tremendously and people with HIV/AIDS have played a significant role in public education on AIDS (African Bank Group 1993b:83).

Zaire is one of those countries in the Central Africa Sub-region which has devised a number of these AIDS prevention motivation campaigns. For example between 1988 and 1990 musicians here worked in collaboration with the Ministry of Health and the Media industry to launch a huge television and radio campaign against AIDS. In pre and post campaign surveys, the percentage of respondents spontaneously citing fidelity as an HIV prevention strategy increased from 29% to 46% while the percentage of condom use increased five fold. During the same campaign, condom sales increased in Zaire by 1000% from 900,000 in 1989 to 18 million in 1991 (African Bank Group 1993b:84). Highlighting the important role these sensitization campaigns play in changing behaviour and with particular

reference to Zaire, WHO confirmed that in Zaire the most outstanding achievement is the dramatic year by year increase in condom use. In 1987, fewer than half a million condoms were distributed mainly by government clinics to a population of nearly 30 million people. The sale of condoms during this period totalled less than 100,000. But by 1991, condom sales had soared to over 18 million (WHO 1992:3).

Community Mobilization Programmes

Community Mobilization programmes which are well known in some African countries especially those severely inflicted by HIV/AIDS have been found to be quite useful because they hasten, exposure to peer endorsements of change and to peer role models for change. Specific interventions here include person to person communication through peer educators or outreach workers, and assistance to the community in developing local organisations. These community programmes which have been targeted at high risk groups have succeeded in changing the behaviour of a good number of people. The peer to peer approach is the most effective way of reaching the youth and it is a suitable complement to like skills education which should be made an integral part of the school curricular since it has the potentials of helping the youth to better control their lives.

One of the most effective approaches reviewed by WHO, is a community-based programme in Zimbabwe where much HIV transmission is from men who have sex with casual partners and then pass the virus on to their wives. The programme organisers chose commercial workers and community actors and musicians to act as educators. Using these people to promote condom use among their peers and warn them personally against the danger of HIV infection, has been quite successful in boosting condom use, proving that advice and support from others in the community are powerful AIDS prevention tools (WHO 1994:21).

In view of the apparent impact of HIV/AIDS among the youth in Rwanda, the authorities of six districts have taken the responsibility of mobilizing the youth against AIDS. With the help of the Ministry of Youth and Associative Movement of Rwanda, they have created out of school youth associations to examine and suggest solutions to the problems facing the youth population including that of HIV/AIDS which seems to be the major preoccupation of every African today. Because of the participative and the indigenous character of the association, its impact has been felt through out all the districts involved. The issue of AIDS is addressed in the broader context of like skills development. Other known activities undertaken by the association include sport, drama and film viewing. This is organised specifically by the youth themselves under the control and supervision of a district staff trained in youth mobilization. These activities have helped in changing behaviour such as reduction of alcohol

consumption, adoption of positive gender attitudes, positive attitudes towards people with HIV/AIDS and safe sexual habits including abstinence and consistent use of condoms (African Bank Group 1993b:84).

In view of the recorded successes of the Rwanda programme in changing the behaviour of the youth, the Ugandan Government recently launched a similar programme called Saved Youth from AIDS (SYFA). The only difference from that of Rwanda is that this one is supported by religious bodies, NGOs, and the local communities. Local initiatives in favour of young people facing the threat of AIDS have also been carried out in the copper-belt region of Zambia and Botswana. In order to empower the affected youths, attempts are being made to either help them return to school, provide them with vocational training or promote income generating activities for them. These programmes have been quite successful because HIV/AIDS messages have been integrated with other topics of interest to young people such as relationships, sex, school and employment.

Community mobilization programmes are also quite suitable for women because women individually may find it impossible to change their partners' behaviour but collectively they may change community sexual norms and behaviour. These programmes have been quite successful among highly sexually active groups such as commercial sex workers, their clients, truckers, soldiers and fishermen. The fact that these people share common experiences and concerns or work and live together makes the programmes or approaches particularly suitable for them. To reinforce and promote this approach, in Tanzania, Botswana, Zimbabwe and Uganda, the governments, trucking companies, unions and NGOs have developed plans to mount person to person education programmes with a view to halting the spread of HIV/AIDS epidemic (African Bank Group 1993b:85-86).

Confirming the efforts which are being made by the various groups in Africa to halt the spread of the AIDS pandemic, WHO observed that the private sectors in some countries are playing an important role in the reduction of job-related high risk behaviour. For example the trucking companies and unions of Tanzania, the Zimbabwe bi-partisan employer-union, National Employment Council for the transport industry, the Copper Belt company of Zambia and the Coca Cola and Shell Oil Companies of Kenya have joined efforts with Governments and NGOs to either mount person to person education programmes or help finance programmes to mobilize workers through national wide peer education networks (WHO 1994:3).

These mobilization programmes, it is true have been quite effective in helping people to change their behaviour. However, one must also admit that they have so far focused only on condom use without addressing the underlying and basic issues such as gender disparity, poverty, employment and so on which often push young people to get involved in high risk

behaviour. Considering the economic crisis which most African countries are currently facing, the number of young women engaged in commercial sex work for survival will definitely increase. Consequently, there is need to devise other approaches and strategies which will focus on issues of concern to women such as education, poverty, employment, political participation, etc. There is the need also to examine other alternative sources of income for women and youth and also to reduce the rate of urbanization.

Condom Promotion

Condom promotion, it has been admitted the World over, is a very useful HIV prevention strategy. They must therefore be made available in all countries of the world since HIV/AIDS is a universal disease. As pointed out by the African Bank Group (1993b:86), recent evidence suggests that well designed condom promotion campaigns can lead to dramatic increases in the demand for condoms. For example, 'Condom Social Marketing (CSM) which is the promotion and sale of condoms at subsidized prices using private and informal net works, energy and salesmanship, have had a degree of success in Africa where the number of CSM programmes rose from 1 in 1986 to 20 in 1992.

Supporting this view, WHO observes that there are signs in Sub-Saharan Africa that it is possible to encourage people to change their behaviour to avoid infection. For example 'more and more condoms are being sold and distributed, and there is increasing anecdotal evidence that bars and discos that serve as sex trade centres are losing clientele. Rates of sexually transmitted diseases (STDs) reported from primary health clinics in Harare, Zimbabwe show a substantial decline to up to 63% between 1990 and 1993. All of this point to encouraging changes in sexual behaviour (WHO 1994:2).

It is however important to mention that any successful condom campaign will depend on the support and good will of the government. For example realizing that the 300,000 condoms distributed free each year to Zaire's 38 million people were insufficient to reduce HIV transmission, the Government commissioned a Social Marketing Programme in 1988. After consumer research 'Prudence' the condom for the man who was sure of himself was launched. Conventional distribution outlets such as pharmacies, dispensaries and health centres were saturated with condoms which were promoted through point of purchase advertising, rock concerts, bar parties, prudence T-shirts and shopping bags. After this, an 18 months survey was undertaken and the findings revealed that consumers were largely confined to the educated middle class. To reach the other segments of the population distribution was extended to large companies, NGOs, hotels, bars, night clubs, street vendors and traditional healers. In 1989, the project was extended to the cities of Goma and Matachi and by 1991 it had been established in 10 out of 11 regions in Zaire (African Bank Group 1993b:87).

Apart from this, WHO has also revealed that in Côte d'Ivoire, condom sales have reached 6 million a year, in Zambia 440,000 condoms were sold in the first 19 days of a Social Marketing programme while in Burkina Faso in just four months 2.7 million were sold through 68 wholesalers and over 800 retailers (WHO 1994:3).

Prevention of STD and Transmission Through Contaminated Blood

Medical professionals have revealed that untreated STDs can facilitate both the acquisition and subsequent transmission of HIV. The control of STDs through early diagnosis and treatment is therefore, an important control measure that would directly reduce the spread of HIV. To accomplish this, efforts should be made to ensure that STD services are made not only available but that they are appropriate, accessible, convenient, efficient and non-threatening to the patients. An integrated national STD and AIDS programme according to the report of the Regional Director of WHO, should be established to provide effective leadership and co-ordination in strengthening the capacity of health facilities to deliver their services. STD drugs should be placed on the essential drug list and procurement mechanisms strengthened to ensure optimal economy and efficiency. Syndrome-based STD patient management approaches at all primary health clinics should be used, 'supported by strategically placed referral training and supervision centres (WHO 1992:7-9). In addition, counselling, partner referral, community out reach especially among very sexually active groups and condom promotion should be considered an integral part of all STD services.

While focusing attention on condoms, STD control and other prevention strategies, instruments used at the hospital should not be forgotten. In other words, efforts should be made to prevent the transmission of HIV through injections and the use of other skin-piercing instruments. To reduce the transmission of HIV/AIDS through contaminated blood, attempts should be made to provide a clean blood supply for transfusions. This can be done by ensuring that rapid testing equipment and supplies for collecting blood for eventual transfusion are provided to all health units and on time. Perhaps the most important thing to do is to ensure that blood transfusions take place only when it is absolutely necessary and unavoidable. In the light of this, medical doctors (and even the public) should be adequately sensitized so that they do not get into the habit of prescribing for blood transfusions when other methods could have been used. The best thing to do perhaps is to advise doctors when to transfuse and when other options can be employed. In doing this, patients and even doctors have to be sensitized to the fact that blood transfusion is in fact a high risk behaviour.

The foregoing analysis reveals that threatened by the AIDS pandemic some African countries have devised and adopted a number of preventive

strategies to halt the spread of this deadly disease which have successfully changed the sexual behaviour of a good number of people to some extent. However, these approaches are limited to condom promotion, community mobilization programmes, person to person education and control of STDs without taking the underlying issues which often encourage people especially the youth and young women (the most vulnerable groups) to get involved in these high risk behaviours. Besides, since promoting the use of condoms in many African societies is a sensitive issue, no mention has been made of the fact that in promoting the use of condoms, the local customs and beliefs of the people have to be taken into consideration.

Summary, Conclusions and Recommendations

From the foregoing analysis, it is evident that AIDS is a socio-economic development problem. It affects generally the most productive age group, it is widespread and fatal. It destroys human resources, affects production, consumption, savings and investment decisions and distorts the development of many sectors of the economy especially those which depend on skilled manpower. It affects the demand for schooling, increases drop out rates and reduces enrolment. It increases the number of people in poverty as well as public and private health expenditures.

Africa will not possibly achieve sustainable development if countries continue to allocate a large and growing portion of meagre national resources to the treatment of AIDS cases, if personal incomes decrease due to high mortality rates among working age adults and if 'exchange rates are misaligned, distorting the system of incentives' (Kambou *et al.* 1992:113). Since the AIDS epidemic has its greatest impact on the highly productive segment of the labour force, the current emphasis on a development strategy that is 'people-centred' is bound to fail because a majority of the people involved in this people centred development are being rapidly eliminated by the HIV/AIDS epidemic.

However, some African countries have devised HIV/AIDS preventive strategies which include the promotion of condom use and control of STDS, educational programmes aimed at long distance truck drivers, fisherman and other high risk groups, person to person AIDS messages and care for other sexually transmitted diseases which if left untreated could increase the risk of HIV transmission.

If adequate and carefully designed preventive measures are not taken in the whole region to halt the spread of this deadly disease, then the population growth rate in Africa as suggested by many studies may decline from roughly 3% to 2% per annum, after 25 years (Ainsworth 1993:15), the crude death rate will increase to 21 per thousand in 1995-2000 (Amstrong 1992), while life expectancy will drop from 51 to 43 years on the average

(Ainsworth 1993:10). For the projected life expectancy at birth *with* and *without* AIDS *see* Table 2.

Table 2: Projected Life Expectancy at Birth, With and Without AIDS

		1975-1980	1975-1980	1990-1995	1995-2000
Malawi	with AIDS	43.1	45.4	41.2	43.9
	without AIDS	43.1	47.0	49.0	51.0
Rwanda	with AIDS	45.0	47.2	46.2	45.9
	without AIDS	45.0	48.5	50.5	52.5
Uganda	with AIDS	47.0	44.6	41.8	41.2
	without AIDS	47.0	48.0	50.0	52.0
Zambia	with AIDS	49.3	48.6	44.1	42.7
	without AIDS	49.3	53.4	55.4	57.4
Benin	with AIDS	42.0	45.5	46.3	47.0
	without AIDS	42.0	46.0	48.0	50.0
Burundi	with AIDS	46.0	48.4	48.1	48.3
	without AIDS	46.0	49.5	51.5	53.5
Congo	with AIDS	48.7	52.0	51.5	50.8
	without AIDS	48.7	52.7	54.7	56.7
Zaire	with AIDS	48.0	51.6	51.6	51.5
	without AIDS	48.0	52.0	54.0	56.0

Source: United Nations, 1993, *World Population Prospects*. The 1992 Revision, New York.

In spite of the efforts being made by African countries to fight against the epidemic, Dr. Marson says more needs to be done. In his words 'Africa has developed magnificent models of prevention and care, but these are not yet being replicated widely enough, well enough or fast enough. Every section of the society must be involved-including people with HIV or AIDS who must be welcomed as partners in these efforts. And the commitment must start on top. No doubt top-level political commitment does exist in some African countries, some countries are putting impressive resources into the fight. But too many others are lagging behind in both commitment and resources' (Who 1993:2).

Explaining why some countries are lagging behind both in commitment and resources, Dr. Merson observed that three societal forces were driving the spread of HIV and blocking effective prevention and care. These are denial, discrimination and disempowerment. As he pointed out 'it is clear that until we overcome these societal factors such as denial, discrimination and empowerment, we will never bring the epidemic under full control (WHO 1994:2). In support of this, Dr. Nakayima, Director General of WHO speaking at the opening session of the 10th International Conference on

AIDS said that 'fear, indifference, poverty and denial have been the main enemies to effective HIV/AIDS prevention' (WHO 1994:3).

In view of the foregoing observations, the following recommendations are pertinent. Political leaders in Africa must first of all find the courage to provide leadership despite the sensitivity and taboos around AIDS. They have to accept that AIDS exist and is fatal. Therefore, discriminatory laws and practices must be abolished and those who are powerless must be given the means to protect themselves. Confirming these views WHO argues that 'political, religious and community leaders must overcome their own reticence and speak openly about AIDS, accommodating frank messages within the context of their country's social, cultural and religious norms (WHO 1991:2). Second, total national commitment should be seen as a precondition for the control of HIV/AIDS epidemic. In other words, national response to the pandemic must embrace all segments or facets of the society. AIDS programmes cannot just be seen as the Ministry of Health's programmes. They require action, support and resources from Ministries of Finance, Planning, Education, Information, Labour and Agriculture etc., from the private sector and community groups including NGOs. Effective working relationships between national authorities and community— based groups are essential to bring about social response required to combat the epidemic.

Third, governments must fight complacency and denial and ensure that they commit themselves to equity and justice in confronting the AIDS pandemic. There is certainly need for regional solidarity in meeting the ever-increasing demands on resources of AIDS prevention and of care; and for national solidarity in ensuring that programmes for the prevention and control of AIDS get their fair share of the resources available. In addition, effort should be made to ensure that people with HIV infection and AIDS receive human and dignified care and that they are not stigmatized or discriminated against.

Fourth, prevention programmes which must be initiated early and urgently should focus mainly on the youth, women and very sexually active groups. These programmes must respond to those factors which do lead to the spread of the AIDS virus as the status of women in the society and the socio-cultural and economic pressures that render young people particularly young girls vulnerable to HIV infection. Therefore special efforts should be made to keep these young girls in schools and provide them with skill based education that protects them against AIDS. Prevention programmes must combine media and person to person education with condom promotion and STD prevention and control services that are accessible and acceptable to both men and women.

Fifth, Community — based home care programmes for HIV — infected/ AIDS patients and their families should be established in the region. One

must however admit that some Sub-Saharan African countries such as Congo, Rwanda, Uganda, Zambia, Zimbabwe etc. have developed home care services to cater for the AIDS patients. However, it is important that the quality of these community home-based programmes be improved. To realise this, WHO declares the following mandatory:

- Government should strengthen health systems, in particular primary health care, to include activities in community— based care and control of sexually transmitted diseases and AIDS.
- Clear policies and guidelines should be established on the management and discharge of AIDS patients from facilities in preparation for community/home care.
- Communities should be empowered to strengthen their capabilities for coping with appropriate aspects of management and control of AIDS through effective decentralisation of activities the 'ideal model of home care for Africa' does not exist, but must be developed locally, regionally, nationally with the participation of all persons in the area to be served.
- Governments and NGOs should promote sustainable income-generating activities to enhance the quality of life of people with HIV/AIDS and their families.
- There should be training and capacity building for health and community workers to enhance the quality of life of people with HIV/AIDS and their families.
- A mechanism to monitor on a continuous basis ongoing activities in community/home based care and control of HIV/AIDS should be developed.
- Counselling services should be provided to HIV positive and AIDS patients in all health centres.
- As it is already the case in Burundi, Malawi and Uganda, necessary drugs to care for AIDS patients with recurrent episodes of opportunistic infection should be obtained. Apart from this, educational programmes should be developed for target community groups such as women, youth, community leaders and traditional leaders to participate in providing care for the sick (WHO 1992:9-19).

It is however important to mention that caution is needed, especially to avoid allowing the full burden of home care to fall on females what ever their ages. The distribution of labour within the family should be carefully considered, and communities should develop supportive net works composed of neighbours, religious groups and clubs. This will be easily realised considering the African spirit of generosity and solidarity.

References

African Bank Group : AIDS and Development in Africa, 1993a, Annual Meetings Symposium, Côte d'Ivoire.

African Bank Group, 1993b, 'Prevention and Coping Strategies', Annual Meeting Symposium Côte d'Ivoire.

AIDS TECH/Family International, 1992, 'An Assessment of the Economic Impact of AIDS in Kenya', Paper prepared for the United States Agency for International Development, Memeo.

Ainsworth, M., 1993, 'The Impact of HIV/AIDS on African Development' Paper prepared as background for the *Symposium on AIDS and Development*, African Development Bank, The World Bank.

Amstrong, J. *et al.*, 1992, 'The Demographic, Economic and Social Impact of AIDS', in Main, J. *et al.*, *AIDS in the World*, Cambridge, Harvard University Press.

Burce, A. M. A. *et al.*, 1992, 'Mortality Among Female Nurses in the Face of AIDS Epidemic: A pilot Study conducted in two hospital in Southern Province of Zambia'.

Davachi, F. P., *et al.* 1988, 'The Economic Impact on Families of children with AIDS in Kinshasa Zaire', in A. Felming *et al.*, *The Global Impact of AIDS*, New York.

Hunter, S. S., 1990, 'Orphans as a Window on the AIDS Epidemic in Sub-Saharan Africa. Initial Results and Implications of a Study in Uganda', *Social Science and Medicine*, Vol.31, No.6.

Kambou, G. *et al.*, 1992, 'The Economic Impact of Aids in an African Country: Simulations with a Computable General Equilibrium Model of Cameroon', *Journal of African Economics*, Vol.1, No.1.

Over, M., 1992, 'The Socio-Economic Impact of Adult Death from Aids in Sub-Saharan Africa: A Research Proposal', *Population, Health and Nutrition Division*, World Bank.

Oyekanmi, F. D., 1994, 'Women's Attitude Towards Sexually Transmitted Diseases in Nigeria: A Case Study in Ilesa in Ogun State', *Africa Development*, Vol.XIX, No.2.

Panos Institute, 1992, *The Hidden Cost of AIDS*, Washington DC.

Preble, E. A., 1990, 'Impact of HIV/AIDS on African Children', *Social Science and Medicine*, Vol.31, No.6.

White, A., 1991, HIV Infection and AIDS in Zimbabwe: An Assessment' Southern African Foundation for Economic Research.

WHO, 1991, Press Release WHO/57 November.

WHO, 1992, 'AIDS Prevention Does Work, says World Health Organisation', *Press Release* WHO 44, 22 June.

WHO, 1992, 'Global Strategy for AIDS Prevention and Control: AIDS Situation in the African Region', Report of the Regional Director, Brazzaville.

WHO, 1993, Press Release WHO/101.

WHO, 1994, 'Tenth International Conference on AIDS', Press Release WHO/62/9 August.

---

* Socio-Economic Research and Planning Division (SERPD), Economic Commission for Africa (ECA), Addis Ababa-Ethiopia.