

**HIV/AIDS AND SOCIO-ECONOMIC  
DEVELOPMENT IN SOUTHERN AFRICA**

**"HIV/AIDS AND FOOD SECURITY"**

**Compiled by Clive Bepura, SADC FANR**

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## 1. Introduction

Improved transport networks, trade and migration have led to greater links of communities between and within rural and urban areas. This, coupled with the co-existence of poverty and affluence, a breakdown of culture coupled with a tendency for high life leading to loose morals and promiscuity, has rapidly increased the transmission and prevalence of HIV/AIDS in both urban and remote areas. No other crisis has ever presented such an enormity of a practical

threat to human life, social and economic progress as with the case of HIV/AIDS pandemic. Even if a miracle was to occur and HIV/AIDS eliminated today, the widespread damage and adverse socio-economic effects already suffered on the part of social and economic development will be felt for decades to come.

The pandemic has risen to such proportions that it can no longer be considered a problem of the health sector alone. Unfortunately, "the realization that we need to focus on AIDS as a development rather than just a health problem has only really come in the last year or two", said Stuart Gillespie in 2001 in "The

What is HIV?

**H** - Human - because this virus can only infect human beings.

**I** - Immuno-deficiency - because the effect of the virus is to create a deficiency, a failure to work properly, within the body's immune system.

**V** - Virus - because this organism is a virus, which means one of its characteristics is that it is incapable of reproducing by itself. It reproduces by taking over the machinery of the human cell.

HIV is the virus most researchers believe causes AIDS

What is AIDS?

**A** - Acquired - because it's a condition one must acquire or get infected with, not something transmitted through the genes

**I** - Immune - because it affects the body's immune system, the part of the body which usually works to fight off germs such as bacteria and viruses

**D** - Deficiency - because it makes the immune system deficient (makes it not work properly)

**S** - Syndrome - because someone with AIDS may experience a wide range of different diseases and opportunistic infections.

Unfinished Agenda; Perspectives on Overcoming Hunger, Poverty and Environmental Degradation". Though health-oriented strategies to combat HIV/AIDS have been under way since the 1980s, attempts to address the socio-economic repercussions of illness and death on such a massive scale have only just begun.

Thus HIV/AIDS requires a concerted approach from all sectors to address its social, financial, economic and institutional consequences. Given the critical role of the human capital in all industries, the destruction of both skilled and unskilled labour in the various sectors has forward and backward consequences on economic activity. As a result, the pandemic is taking a great toll on all dimensions of food security; availability, access and food use. Presently each day at least 10 000 people in Sub-Saharan Africa are infected and doomed to die by the year 2010. The death of so many most productive adults will continue to have devastating impact on individual families, communities and national economies.

**What is food security?**

The 1997 SADC Regional Food Security Strategy Framework defines food security as "ensuring that all members of a household, nation and region have access to an adequate diet to lead an active and normal life".

The policy implications are multi-sectoral and require a broad economic development strategy aimed at poverty reduction and sustainable livelihood systems. Thus food security can be viewed as multi-sector objective to which various development sector subscribe.

This paper explores the dimensions of HIV/AIDS at the global and sub-Saharan level, delving into implications for agriculture and food security or rather general economic development, particularly for the southern African region. The paper also discusses actions that can be undertaken to mitigate the effects of the disaster as well as constraints to the effectiveness of such actions. Lastly it looks at the SADC FANR's latest regional response to the pandemic.

## 2. Global Dimensions of the Contagion

Table 1 shows the number of people estimated to have been living with the virus by region in 2000. According to UNAIDS figures in Table I, an estimated 36 million people worldwide had been infected with the virus by the year 2000. About 95 percent of them were found to be living in the developing countries. Tragically, the prevalence of the disease is still increasing today. Since the disease commonly decimates the most economically productive labour, HIV/AIDS is an even more threatening problem of critical importance for agricultural, economic and social development.

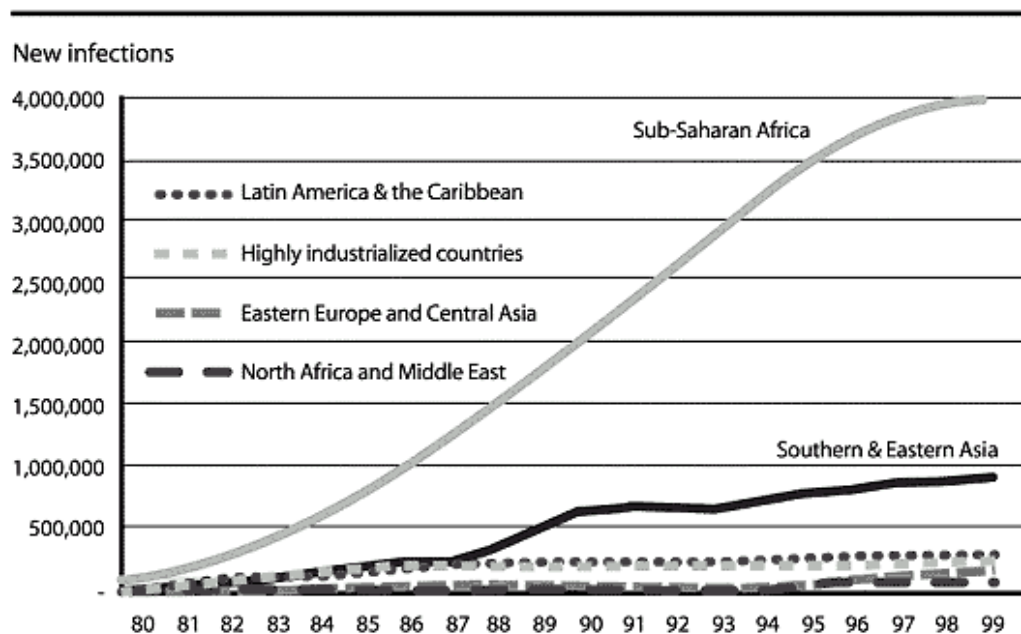
**Table I; Prevalence Of HIV/Aids In 2000**

Region	Number of adults and children living with HIV/AIDS (Thousands)	Percentage of adults living with HIV/AIDS in 2000
North America	920	0.60
Caribbean	390	2.30
Latin America	1 400	0.50
Western Europe	540	0.24
Eastern Europe and Central Asia	700	0.35
North Africa and the Near East	400	0.20
Sub-Saharan Africa	25 300	8.80
South and Southeast Asia	5 800	0.56
East Asia and the Pacific	640	0.07
Australia and New Zealand	15	0.13
World	36 100	1.10
Source: UNAIDS		

Figure I shows the estimated annual growth of infections by region between 1980 and 1999. During that period sub-Saharan Africa had the fastest rate of infections as well as the largest number of infections per given period, according to the graphs below.

**Figure I**

## Estimated annual number of new HIV infections by region, 1980 to 1999



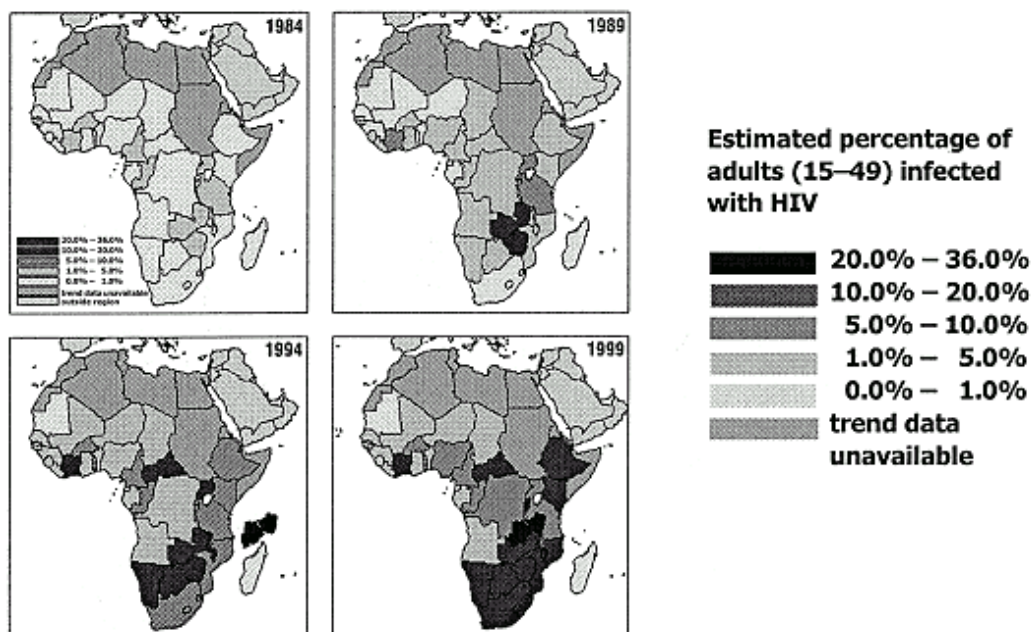
As illustrated in Figure 1 and Table I, HIV/AIDS is a truly global pandemic. However, the predominance at the global level of the Sub-Saharan Africa is very clear. With over twenty-four million people infected, the region had the largest population living with HIV. At 8.57 %, the region had the greatest proportion of adults infected with the virus. The Caribbeans were second in place at 2.11%.

Research has in some cases established a pattern of spread to economic activity. Population groups most at risk have been found to include those situated along truck routes to rural areas, i.e. people who live in areas such as rural market towns and have greater contact with urban centres. Rural zones that are sources of migrant labour and large infrastructure projects have also been identified as areas of high HIV prevalence. For example, HIV prevalence among pregnant women in Agomanya, the administrative centre of the district that abuts on Ghana's Volta dam, is five to ten times higher than in the rest of the country.

While, in terms of absolute numbers, prevalence rates and concentrations may be higher in urban centres, rural people have been affected equally extensively. Studies have established that women are also relatively worse affected. For every ten African men infected, it has been found there are between 12 and 13 African women infected, and the average rates among adolescent girls are three to five times higher than those among boys in the same age group.

In several cases it is the rapid spread of infections that constitute the critical element of the disaster that makes efforts to manage its effects very complex. For instance, less than 1 percent of adults were infected in 1984, yet by the year 2000 the prevalence rate had ballooned to 20 to 35 percent in most of southern Africa as indicated in Figure 2 below.

**Figure 2. Spread of HIV 1984-1999**



### 3. Dimensions of the Contagion in Sub-Saharan Africa

As already indicated, the spread of HIV/AIDS in the sub-continent in the past two decades was rather dramatic. Of the total 36.1 million people estimated to have HIV/AIDS worldwide by 2000, 25.3 million, or 70 percent, lived in sub-Saharan Africa. Approximately 23.4 million of these were in the 15 to 49 years age bracket, with a range of 0.08 to 35 percentage of the total population. By 2001, there were approximately 16 countries in the region with more than one-tenth of their adult population infected and living with the virus. Table 2 below shows the prevalence of the virus in sub-Saharan Africa in ascending order.

**Table 2; Prevalence Of HIV/Aids In Sub-Saharan African Countries, In Ascending Order, 1999**

Country	Number of adults infected (15-49 years)	Percentage of adult population	Country	Number of adults infected (15-49 years)	Percentage of adult population
	<i>(Thousands)</i>			<i>(Thousands)</i>	
Sub-Saharan Africa	23 400	5.57			
1. Mauritius	0.5	0.08	23. Congo	82	6.43
2. Comoros	0.4	0.12	24. Burkina Faso	330	6.44
3. Madagascar	10	0.15	25. Cameroon	520	7.73
4. Equatorial Guinea	1	0.51	26. United Rep. of Tanzania	1 200	8.09
5. Mauritania	6.3	0.52	27. Uganda	770	8.30
6. Niger	61	1.35	28. Ethiopia	2 900	10.63
7. Guinea	52	1.54	29. Côte d'Ivoire	730	10.76
8. Senegal	76	1.77	30. Rwanda	370	11.21
9. Gambia	12	1.95	31. Burundi	340	11.32
10. Mali	97	2.03	32. Djibouti	35	11.75
11. Benin	67	2.45	33. Mozambique	1 100	13.22
12. Guinea-Bissau	13	2.50	34. Central African Republic	230	13.84
13. Chad	88	2.69	35. Kenya	2 000	13.95
14. Angola	150	2.78	36. Malawi	760	15.96
15. Liberia	37	2.80	37. Namibia	150	19.54
16. Eritrea	49	2.87	38. South Africa	4 100	19.94
17. Sierra Leone	65	2.99	39. Zambia	830	19.95
18. Ghana	330	3.60	40. Lesotho	240	23.57
19. Gabon	22	4.16	41. Zimbabwe	1 400	25.06
20. Nigeria	2 600	5.06	42. Swaziland	120	25.25
21. Dem. Rep. of the Congo	1 100	5.07	43. Botswana	280	35.80
22. Togo	120	5.98			
<i>Source: UNAIDS.</i>					

Deaths attributable to the incidents of AIDS in the region summed up to 2.4 million in 2000, compared with 2.2 million in 1999. Tragically, the pandemic has already created 12.1 million orphans in sub-Saharan Africa. Before the materialization of AIDS, only 2 percent of children in developing countries were orphans; by 1997,



the figure was 7 percent in several African countries while in others it was as high as 11 percent.

However, the situation is not as bleak as to be hopeless. A few countries have made significant progress with their control and prevention measures and provide some positive lessons and experiences. Countries such as Senegal and Uganda have been successful in at least curtailing the prevalence rate by implementing strong awareness and prevention programmes including popularly accepting that the problem exists and marshalling strong political support and leadership. Senegal has managed to contain the HIV/AIDS prevalence rate at low levels, while Uganda has brought its estimated prevalence rate down to about 8 percent from a peak of nearly 14 percent in the early 1990s.

In 2000, 3.8 million adults and children in sub-Saharan Africa were infected with the virus, slightly fewer than the 4 million infections recorded in 1999. Generally the rate of infection is slowing down or rather stabilizing in the sub-continent, as the disease has already reached large numbers of people and because effective prevention policy measures achieving some impact. Infections in the southern Africa are still on the increase though and the overall trend will depend on how the pandemic develops in Nigeria, one of the most populous states in the region.

#### **4. The Economic And Social Impact Of HIV/AIDS**

The AIDS pandemic is an enormous health problem with profound socio-economic ramifications at both the household and national levels. It has created exorbitant health expenses and economic waste for households and economies through care costs, labour deaths, eroding household asset bases, breaking down the cultural and social relationship and contributed to economic meltdown at household and national levels.

The pandemic damages economic development prospects through early death of the economically productive. It has greatly reduced life expectancy in the SADC region by as much as 40% in some countries. An average of 17 years of life expectancy has been lost in countries where the adult HIV/AIDS prevalence rate exceeds 10 percent. What is unique to HIV/AIDS is that it mainly affects the most productive age group - people aged between 15 and 49, leading to loss not only of young talent and skills, but also output. As employment, productivity and efficiency are affected in individual industries, national economic outputs will be affected. This will be felt more the stronger the forward and backward linkages and multiplier factors between sectors.

At the national level, economic resources allocation is directly affected by the pandemic as private and public resources meant for productive investment and infrastructure are diverted for use on increased demands from the health sector. In urban areas of Côte d'Ivoire, household expenditure on schooling was found to have fallen by 50 percent when someone in the family dies from AIDS. Food consumption falls by 41 % per household member. Spending on health care increases by more than four times as much.

When it strikes, it also creates a tremendous burden for households. Medical and funeral expenses force many of the poorer households into debt. More than one-third of the gross national product of the worst affected African countries comes from agriculture. Typically agricultural systems in these countries are labour-intensive with a low level of mechanization and agricultural input and are therefore particularly vulnerable to the pandemic.

The average gap from the time of infection to the time of death is on average eight to ten years. Studies have indicated that the gradual onset of AIDS in the last two of those years lead to reduced labour productivity and escalating health care costs. Companies lose directly through lost hours due to illness, stress and eventually death of workers as well as funeral attendance and home care.

A World Bank study on Kagera district in the United Republic of Tanzania revealed that the total cost of to a household was about \$60. This was further found to close to the annual per capita income in Kagera. About 60 percent of the cost of an AIDS victim was found to be used to cover funeral costs. Other evidence from Tanzania suggested that food expenses incurred by poor households could drop by nearly one-third during the six months after the death of a young adult.

It has also been found through research that AIDS does not only lower the demand for schooling, but also impedes the supply side by creating a serious shortage of teachers as well as curtailing teaching hours through illness and care. For instance, an equal number of teachers were lost to retirement as were

to death over the 1996 to 1998 period in the Central African Republic. Of the dead, 85 percent were found to be HIV-positive.

It has over the past two decades become fact that HIV/AIDS has taken over all other diseases to become the number one killer and one of the main factors in calculating disability-adjusted life years in Africa south of the Sahara. The pandemic is associated with other infectious diseases, such as STDs, tuberculosis and pneumonia. Hospital records indicate that up to 40 percent of HIV-infected patients are afflicted by tuberculosis.

As already indicated, treatment costs of HIV/AIDS patients are very high and beyond the means of most urban middle-income households, not to mention rural and urban low-income households. The table below shows the estimated direct cost per each case of HIV/AIDS against the per capita GDP in selected SSA countries for the period 1989 to 1992. Except for Zimbabwe at the time, in all cases the per capita GDP was lower than cost per each case.

The situation for Zimbabwe has since changed, with GDP having fallen to less than US\$ 300 by 1999. The overall summation of these economic indicators is that neither an average household nor our economies can afford to provide adequately for the cost of HIV/AIDS affliction.

**Table 3; The Cost Of Aids In Selected Sub-Saharan African Countries**

Country	Direct cost of AIDS per case	GDP per capita
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	(\$)	
Kenya (1992)	938	333
Malawi (1989)	210	203
Rwanda (1989-90)	358	269
United Rep. of Tanzania (1990)	290	204
Zimbabwe (1991)	614	648
<i>Source: M. Ainsworth and M. Over. 1994. AIDS and African development. The World Bank Research Observer, 9(2): 203-240.</i>		

At national level the pandemic has forced governments to divert development expenditure towards the health sector, thereby diverting funds from productive investments. For instance, the cost of treatment of AIDS and related infections has been estimated to increase and exceed 30 percent of the budget for the Ministry of Health in Ethiopia by 2014, and 50 and 60 percent in Kenya and Zimbabwe, respectively, by 2005. This implies an opportunity cost realized through a gradual decrease in resources available for productive investment leading to reduced economic output in the medium to long run as a result.

In countries where surplus labour exists, one might argue that the onset of decreasing output will take longer to be realized or is not yet being realized. However, a point will be reached in the medium to long term where productivity and output will begin to fall as a result of the gradual decimation of labour as critical factor of production in developing world agriculture. Indeed GDP per capita may be an inappropriate yardstick to use when measuring the impact of AIDS in developing countries because it does not accurately capture the serious setback in development suffered as a result. The socio-economic effect and impact of the disease and in terms of rural and urban livelihood systems at the poor household level need to be traced in a more comprehensive manner.

## **5. The Impact Of HIV/AIDS On The Agriculture Sector**

In most of Sub-Saharan African countries, agriculture provides the basis for livelihood for 70 to 80% of the population. It also supplies food to both urban and rural sectors, generates foreign exchange and employment. In particular it supplies raw materials to industries and a services market through its forward linkages and also provides demand and huge market for the agricultural inputs industry through backward linkages.

Finally agriculture provides "final demand linkages" through the multiplier effects up and down stream especially through the non-basic sectors (economic activities whose transactions are local and directly agricultural production-related; services, housing, etc). Thus a fall in agricultural efficiency and output as a result of the pandemic affects the rest of the economy through these direct, indirect and induced economic linkages.

Given the above, it needs to be emphasized that agriculture is affected by HIV/AIDS in several intricate ways. The most obvious is the direct drain on the agricultural labour force, both unskilled and skilled. This occurs at two levels; firstly as a result of the loss of the victim's labour and secondly through labour time dedicated to care for the sick. However other losses will be discussed below.

Estimates of 2000 by the FAO have indicated that in 27 most affected countries in Africa, 7 million agricultural workers died from AIDS since 1985, and 16 million more deaths were expected in the next two decades.

By the year 2000, 12 of these countries are estimated to have lost 2 to 13 % of the agricultural labour to the virus. In the ten most affected African countries, labour force decreases are anticipated to range from 10 to 26 percent by the year 2020. See Table 4 below.

**Table 4: Impact of HIV/AIDS on agricultural labour force in the most affected African countries**

(Projected losses in percentages)

	<u>2000</u>	<u>2020</u>
Namibia	3.0	26.0
Botswana	6.6	23.2
Zimbabwe	9.6	22.7
Mozambique	2.3	20.0
South Africa	3.9	19.9
Kenya	3.9	16.8
Malawi	5.8	13.8
Uganda	12.8	13.7
Tanzania	5.8	12.7
Central African Rep	6.3	12.6
Ivory Coast	5.6	11.4
Cameroon	2.9	10.7

Source: FAO/SDWP

While it is difficult for lack of data at present to estimate with precision the loss of agricultural man-hours and production suffered by these countries as a result of this ruin, it is likely that substantial decreases in output will be felt as we proceed towards 2020.

Studies have shown that in the worst affected areas of Thailand, about one-third of rural families affected by AIDS experienced a halving of their agriculture output, threatening their food security. Around 15% had to withdraw their children from school, and over half the elderly and infirm were left to fend for themselves.

In Kenya's Ministry of Agriculture, AIDS causes an estimated 58% of all staff deaths, while some 16% of staff in Malawi's Ministry of Agriculture and Irrigation are living with the disease. Researchers have calculated that HIV/AIDS is causing the loss of up to 50% of agricultural extension staff time in sub-Saharan Africa.

The pandemic has also been found to affect particularly agricultural extension workers. Generally, the situation in the sub-continent is such that there already exists a staff shortage for agricultural extension due to various reasons such as government budgetary constraints, transport and housing problems. Thus the AIDS pandemic worsens and further depresses agricultural productivity. One Ugandan extension officer discovered that about 20 to 50 percent of all person-hours per annum among extension staff was lost as a result of the disease.

Seasonal labour shortages are particularly serious in agriculture, yet correct timing of farmer operations such as ploughing, planting and weeding are critical. The reduction of household labour due to the AIDS and care for the afflicted worsens the agricultural labour shortages, leads to reduction of areas planted, increases fallow and derelict hectares, and reduced food availability, access and nutrition.

An FAO study of several farming areas concluded that declining farmer labour and skills lead to falling farm yields as a result of declining soil fertility; increase in pests and diseases; disruptions and delays in cropping practices; and failure to afford yield-enhancing inputs. A tendency for farmers to switch to less labour- and skills-intensive crops has also been observed in AIDS-afflicted households.



A study of AIDS-afflicted households in Ethiopia concluded that there was a reduction of 50-66 percent of labour time devoted to agriculture as a result of the affliction as compared to households that are not afflicted. In Tanzania it was also found out that when their husbands became afflicted women spent about 60 percent less time on agricultural activities. It is also estimated that by the time one person dies of syndrome, approximately 2 person-years of labour would have been lost due to their weakening and the time others spend giving him/her care.

The pandemic has been observed to lead to grave consequences for agricultural estates such as increased operational costs due to increased absenteeism owing to sickness, substantially reduced productivity and higher overtime costs as other workers replace the sick colleagues. One estate company in Kenya discovered that over a period of eight years in the 1990s its expenditure on employee funerals and health costs increased five and ten times as much, respectively. The company also found out that 75% of the illnesses among its employees were related to HIV infection.

Evidence from Namibia and Uganda indicated that the pandemic's impact on the livestock sector could be severe leading to stress animal sales to meet expenses for the sick as well as pay for funeral expenses. Livestock constitute one for the greatest assets comprising a store for value, social and traction power, savings and wealth. Disposing them as a result of the pandemic not only destroys an important part of the social fabric of the household, but also eats into a family wealth and means of production, making the remaining family members poorer and more susceptible to internal and external shocks. The price paid can

therefore be failure to recovery and lower prospects for long-term development for rural and farming areas.

It is also important to note that by striking people in their prime stages of working and parenting lives, AIDS hinders knowledge and expertise from being passed on to subsequent generations. The effects have been particularly harsh in SADC region as noted from the rapid spread of the pandemic in the past two decades. A study in Kenya has shown that only 7% of farming households headed by orphans have adequate knowledge of agricultural production.

## **6. Constraints to Effect Prevention and Mitigation in Rural Sectors**

### ***6.1 Poverty as the Greatest Barrier***

Poverty poses the greatest barrier that denies the rural and urban poor many of the social and economic safeguards that are available to the well-to-do. The incidence of HIV/AIDS exacerbates these barriers by further drawing the poor into deprivation, breaking down social and cultural ties, breeding stigmatization and orphanage. Thus usual constraints surrounding poverty are further reinforced by the pandemic.

### ***6.2 Poor Access to Information and Services***

In particular access to information and health services is poorer in rural areas than in cities. Thus the rural poor are not well positioned to know how to protect themselves against HIV. If they fall ill, they are likely to receive minimal professional care if at all.

### ***6.3 Exposure of Rural Communities***

Rural communities bear especially heavy burdens, as many HIV-infected urban dwellers tend to return to their rural communities when they fall ill. Several studies have proved that HIV/AIDS prevalence rates are unusually high among mobile and high-way populations, thereby disproportionately exposing agriculture, transportation and mining sectors to even greater risks.

#### ***6.4 Vulnerability of Wives and Husbands***

Wives to migrant husbands or vice versa (e.g. cross-border traders) are especially vulnerable to HIV/AIDS, as their spouses may be prone to having other sexual partners on their tour of duty. In addition, some women may engage in transactional sex to earn money or other commodities in times of economic insecurity. Due to women's cultural position and role in African society, the burden of HIV/AIDS falls on them as agricultural workers, caregivers, educators and mothers. At the same time, in some countries, their legal, social and political status make them more vulnerable to HIV/AIDS.

#### ***6.5 Traditions and Inheritance***

In some cases, traditions meant to integrate widows back into the family contribute to the spread of HIV. An example is the custom that obliges a man to marry his brother's widow. Unfortunately, initiatives to stop these practices, while effective in slowing the transmission of HIV, may also leave widows without access to land and food.

Studies in several countries have found that some rural women whose husbands have died of AIDS have resorted to commercial sex as a means of survival,

because they had no legal rights of inheritance to their husbands' property or were simply pushed out.

### ***6.6 Culture, Attitudes and Practices***

Often HIV/AIDS is not acknowledged as attitudes and practices related to sexual behaviour are not openly discussed in most cultures. It is in African culture sometimes difficult or taboo to openly discuss many topics, for example, vulnerability to high-risk sexual practices; multiple sexual partners outside of marriage; the spread of the disease by people who travel widely; the exploitation and sale of children and women into prostitution; homosexuality and HIV/AIDS in prison populations.

When these social factors are combined with the great lack of public information on the extent, causes, consequences and means of preventing HIV/AIDS, efforts to deal with the pandemic are seriously constrained. A strong reluctance to recognise and address the real situations that contribute to the spread of HIV/AIDS is common. In both developed and developing countries, high-risk sexual behaviour and intravenous drug abuse may be at the heart of the contagion; yet most governments and societies have failed or shied away from dealing effectively with the root causes.

### ***6.7 Stigmatisation and Marginalisation***

Stigmatisation and marginalisation of people and households living with HIV/AIDS is another constraint. Such discrimination can interfere with the transmission of prevention messages; discourage the adoption of voluntary counseling, testing and access to early care; give the appearance that individual and social denial are legitimate and make it difficult for people living with HIV/AIDS to be involved in mitigation efforts and for people who are not infected to talk about the virus and adopt safer practices.

The HIV/AIDS pandemic and strategies for mitigating its impact are often not given specific attention by rural development workers. Projects operating in high-prevalence areas inadvertently bypass the households struck by the pandemic, as those households have neither time nor resources to participate in, and benefit from, project activities. This frequently leads to further marginalisation and destitution of affected households.

### ***6.8 High Cost***

As already indicated above, the virus causes direct medical and funeral expenses and labour-related indirect costs. Potential income is lost due to illness and care. The impact is debilitating on farm and off-farm activities. All sectors involved in the development of rural sectors, whether at planning, design and implementation of rural and agricultural development stages, are adversely affected. These costs to the farm and the economy have the effect of wearing down the productive capacity of the country's agricultural system.

At the household level, lack of adequate health care and social services limit initiatives to combat the pandemic through medical treatment. The high cost and limited availability of drugs to fight both the primary HIV infections and secondary infections and associated opportunistic diseases become serious constraints to effective HIV/AIDS programmes.

## **7. A Perspective on Responses to the HIV/AIDS Crises**

### ***7.1 Introduction***

HIV/AIDS presents an unprecedented humanitarian and developmental challenge of an enormous scale. Twenty years after the first case was diagnosed, there is neither a cure nor vaccination for the disease. Medical researchers and doctors have of recent become mute about the prospect of a cure or vaccination. However, experience from several countries indicates that there are other ways of confronting the challenge leading to the reduction of the impact of the pandemic.

For instance the pandemic peaked in Uganda during the early 1990s with an estimated 14 percent of the population affected. Ten years later, levels of infection have been halved following the adoption of appropriate prevention methods and programmes of mitigation. Uganda's National AIDS Control Programme included strong political support and involvement, training community leaders and mobilising the community; innovative communication techniques to change attitudes; reduction in discriminatory practices and involvement of people living with AIDS in care and prevention activities.

Another positive experience was observed in Thailand where infection rates for 2000 fell from an estimated 1.4 million to 984 000 projected in 1994. This rapid turnaround

of the trend was a result of a shift toward a comprehensive and multi-sectoral development approach in Thailand. The National AIDS Prevention and Alleviation Plan marshalled the society against stigmatisation; strongly exploited the mass media; promoted the use of condoms; and integrated information about HIV/AIDS into community education and development service programmes.

While actions to respond to HIV/AIDS will vary, experience indicates that several principles underlie successful initiatives to combat the pandemic. Some of these are discussed below.

### ***7.2 Dynamic leadership and political commitment***

Without the support and commitment of high political and social institutions, the policies, programmes and resources required to cope with the pandemic will not be forthcoming or will simply falter. Endorsement at the highest political level for cross-sectoral action is an essential step. This enables society at large to acknowledge the HIV/AIDS problem as well as accept responsibility for addressing it.

### ***7.3 Prevention of HIV/AIDS Spread***

Without conscious adoption of policies, strategies and programmes for recognizing and halting the spread of the disease at both national and local levels, efforts to address and mitigate its effects will never be effective. As a starting point each

government must decide how its ministries and development partners can contribute to prevention efforts and reinforce this with resource allocation and monitoring progress and impact. NGOs and other sectors should also take cue.

#### ***7.4 Assistance And Development Initiatives for Prevention***

The basic goal of this aspect is to create the necessary economic conditions within which both infected and non-infected individuals can live with dignity and security even in highly affected areas. Meeting the immediate food and other basic needs of poor households is essential. Altering risky sexual and social behaviours including trading of sexual favours for food, goods and services, through various forms of messages and programmes, is crucial to the AIDS prevention goal.

This particular example is especially important as the poverty arising from HIV/AIDS spreads and creates greater destitution among adolescents, orphans and young adults who must then look for ways to survive. Given the importance of information and communication, strong advocacy strategies to raise awareness of governments, policy makers, ministries, opinion leaders and the general public about the impact of HIV/AIDS are crucial.

#### ***7.5 Multi-Sectoral, People-Centred And Community-Based***

The widespread incidence of HIV/AIDS reinforces problems already existing and associated with poor communities. These include poverty, food insecurity, discrimination and social stigmatisation, time and labour constraints, disability and untimely death. The same basic participatory appraisal and planning approaches for developing and implementing appropriate solutions should be employed.



## ***7.6 Reciprocal Incorporation Of HIV/AIDS and Food Security Programme***

### ***Objectives***

The intention is to mainstream or filter HIV/AIDS prevention and control measures into all development efforts at the multi-sector level. The constraints that HIV/AIDS produces at household, community and national levels would then be recognised and addressed through policies and programmes of all sectors. This ensures HIV/AIDS awareness and action not as a health problem only, but as a national priority needing common mainstreaming into national development planning. On the other hand, HIV/AIDS policies and programmes need to recognize their link with and importance to food security issues and should therefore also integrate and mainstream the respective policies and objectives.

### ***7.7. Recent Developments Within SADC FANR***

The HIV/AIDS pandemic is a focus of increasing concern in the SADC FANR sectors, not only with regard to the serious health and social implications of the disease, but also because of its negative effect on agriculture, industry and food security.

Since the advent of the pandemic HIV/AIDS programmes in SADC have concentrated on reducing the transmission of the disease, assisting affected households to cope with the effects and dissemination of information. The programmes have until recently been health sector specific with minimal or no participation of other sectors.

Although studies have been conducted to assess the impact of the pandemic on the FANR sectors, especially agriculture, they have not yet yielded results in terms of

influencing policy. It is only recently that the importance of treating the problem at the multi-sectoral levels has come to the fore.

As a result, the Council of Ministers assigned the SADC FANRPAN to coordinate a study on HIV/AIDS in the FANR sectors. The overall goal of the study to be undertaken in collaboration with SAPES (node), "is to investigate .....the threat thereof to public health and the socio-economic development of SADC member states" and suggest strategies for implementation. The research will cover all SADC countries over a time period of three years and implemented through country nodes. The project is currently at the proposal level though at an advanced stage. HIV/AIDS researchers in the region will also be consulted and invited to make their input at the appropriate stages.

## **9. Conclusion**

Very few of the poverty reduction and agricultural policies and programmes in SADC are not impacted on by the pandemic. Families that lose productive labour and skills are left with less or no ability to meet their livelihood. Each time a family member falls sick or dies they lose through medical and

funeral expenses as well as loss of production and leadership skills. A holistic approach to the problem has become long overdue. In general, policies must go beyond the health sector and HIV/AIDS prevention and look at long-term issues of mainstreaming HIV/AIDS issues into livelihood maintenance and food security.

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