UNAIDS

ECOWAS

HIV/AIDS IN WEST AFRICA: A REGIONAL OVERVIEW

HIV/AIDS across West Africa: The Prevalence, Impact and Response.

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Acronyms:

AIDS	**Acquired Immune Deficiency Syndrome**
CIDA	**Canadian International Development Agency**
ECA	**Economic Commission for Africa**
GTZ	**German Development Agency**
MTCT	**Mother to Child Transmission**
MTT	**Mobile Task Team**
STI	**Sexually Transmitted Infection**
HAART	**Highly Active Anti-retroviral Therapy**
HIV	**Human Immuno-deficiency Virus**
PLWA	**Persons Living with AIDS**
PLHIV	**Persons Living with HIV**
VCT	**Voluntary Counselling and Testing**

1.0 Overview of HIV/AIDS across West Africa

" Nowhere has the impact of HIV/AIDS been more severe than Sub-Saharan Africa. All but unknown a generation ago, today it poses the foremost threat to development in the region. By any measure and at all levels, its impact is simply staggering…" (World Bank, 2000)

The problem and impact of HIV/AIDS in Sub-Saharan Africa is well known particularly in Southern and Eastern Africa. Surprisingly, little research has been carried out to analyse the impact across West Africa. This study is an attempt to prepare governments within region to recognise and consider the macro and micro impacts of the HIV/AIDS epidemic before it is too late. The following report provides an overview of some of the most pressing concerns, which countries within West Africa and their partners will face in the next five to ten years. Governments in West Africa must brace themselves for the 'coming storm', which threatens to:

- Substantially reduce their productive labour force
- Cripple an already fledgling macro and micro economic environment
- Gradually reduce the Gross Domestic Product
- Reduce productivity in all sectors of the economy
- Substantially lower the life expectancy rate
- Place increasing burden on families and health systems
- Increase the number of orphans
- Change the demographic profile
- Wipe out entire communities

Time is short and the spread of HIV/AIDS is quickly reaching higher proportions within the sub-region, transferring the full impact of the epidemic from the family and community to the nation. Already trends across the region suggest that countries with high rates of HIV/AIDS among sex workers are set to move from epidemic to pandemic levels if drastic measures are not put in place immediately.

This study provides an overview of the impact of HIV/AIDS from a multi-sectoral perspective, the response and strategies already in place and those which are proving most efficient at regional, national and community levels. The first section will provide a situational analysis of the incidence and prevalence of HIV/AIDS within Africa and the sub region along with some discussion on the main characteristics and causal relationships. The second section presents an analysis of the impact from a micro and macro perspective exploring the social, and economic impact of the virus. The third section explores the regional, national and community level responses across the West Africa. Annex 8 contains country reports related to HIV/AIDS status and socio-economic background information.

Methodology

This study was based on a desk review of literature, collected from four main sources: UNAIDS, UNESCO, the World Bank, and GTZ. Interviews and data were also collected from the UNAIDS Inter-country Team for West and Central Africa (ICTWCA) in order to update information from countries within the sub region. The major analysis is based on the UNAIDS/ECA (2000) Country-by-Country Report prepared for the Africa

Development Forum, the UNAIDS (2000), Epidemiological Country Fact Sheets and country summaries prepared by the UNAIDS Inter-country team for West and Central Africa (ICTWCA). Prevalence data contained in this study is based primarily on UNAIDS/WHO and data collected by the UNAIDS ICTWCA.

1.1 West Africa in Context

Little research has been conducted to date with specific focus on the AIDS epidemic across the West Africa. Despite the presence of several cross border HIV/AIDS programmes, little research on the prevalence and impact of HIV/AIDS in West Africa is available apart from surveys conducted by UNAIDS (i.e. Country by Country assessment) which provide only limited analysis of the impact (UNAIDS/ECA, 2000). A few studies were found on countries within ECOWAS but these were either outdated or focused on a particular theme and often covering only a few countries within West Africa (World Bank/UNAIDS, 2000d).

Data from the UNAIDS/ECA (2000) and UNAIDS/WHO (2000) suggest that the epidemic is growing at a rapid rate within Sub-Saharan Africa. Table 1.0 presents the status of HIV/AIDS within West Africa compared to the Global and Sub-Saharan African figures.

Table 1: Global, Sub-Saharan and West African HIV/AIDS Burden, December 2000.

Key Indicators	**Global Indicators (UNAIDS, 2000)**[1]	**Sub-Saharan Africa (UNAIDS, 2000)**	**West Africa**[2] **(UNAIDS, update 2000)**
New HIV infections in 2000	5.3 million	3.8 million	N.A.
Number of People Living with HIV/AIDS (end of 2000)	36.1 million	25.3 million	4.782 million
Deaths due to AIDS in 2000	2.6 million	2.2 million	462,800
Adult Prevalence Rate (%)[3]	1.1 %	8.8%	3.7%
Percentage of HIV positive adults who are women (%)	47%	55%	55%
AIDS orphans as of 1999 (under 15 years of age)	N.A	N.A	1.9 million
Cumulative number of AIDS orphans since the beginning of the epidemic	13.2 million[4]	12.1million	2.7 million

(Based on UNAIDS Update, 2000 and UNAIDS report on Global Epidemic, June 2000; N.A. means not available)

Table 1.0 reveals the impact HIV/AIDS in Sub-Saharan African and the potential devastation it threatens to have in West African countries.

- UNAIDS (2000d) estimated that out of the 36.1 million people are infected by HIV/AIDS -- over 70% live in Sub-Saharan Africa.

[1] Global and Sub-Saharan figures are based on UNAIDS update 2000 and ECOWAS country figures are based on 1999 figures.
[2] Data not available on Cape Verde
[3] The proportion of adults (15-49 years of age) living with HIV/AIDS in 1999 using 1998 population figures.
[4] Report on the Global HIV/AIDS epidemic (UNAIDS, 2000b).

- Sub-Saharan Africa has the highest rate of infection amongst adults and children in the world. Out of the 5.3 million of newly infected cases, 3.8 million live in Sub-Saharan Africa. South and Southeast Asia follow with 1.3 million, Latin America has 1.3 million and North America has 920,000.

- 95% of the people infected by HIV/AIDS live in developing countries. **ECOWAS Countries contain 13.6% of the total number of people living with HIV/AIDS globally** (UNAIDS/ECA, 2000).

- 84% of the people who have died from HIV/AIDS since the beginning of the epidemic are in Sub-Saharan Africa and over **10%** are from ECOWAS countries.

- Life expectancy at birth in southern Africa rose from 44 years in the 1950s to 59 in the early 1990s; it is now set to drop to just 45 years between 2005 and 2010 because of AIDS (UNAIDS, 2000d).

- 90% of the children infected by HIV through mother-to-child transmission are in Sub-Saharan Africa. The majority of the AIDS orphans are found in Sub-Saharan Africa. Approximately 1.9 million AIDS orphans are currently living in ECOWAS countries (UNAIDS/ECA, 2000). This is further explored in section 2.2.

- There is a significantly higher ratio of women to men living with the HIV infection in Sub-Saharan Africa. For every 12-13 African women infected by HIV there are 10 African men.

UNAIDS (2000) predicts that the huge gap in HIV infection rates and AIDS deaths between Africa and the rest of the world is likely to grow even larger in the coming ten years. The picture is not promising.

The impact on women, youth and children

One characteristic of the pandemic of HIV/AIDS in Sub-Saharan Africa is the impact it is having on the female population. At the end of 1999, UNAIDS/WHO estimates that 12.2 million women and 10 million men aged between 15 to 49 were HIV infected in Sub-Saharan Africa. Most areas of the world women make up between 10% to 30% of the HIV positive population. In Sub-Saharan Africa, 55% of women out of the total HIV/AIDS population are HIV/AIDS infected and the gap is growing. The reasons for the high rate of female infection in Sub-Saharan is not fully understood but some reasons identified include: "greater efficiency of male to female HIV transmission through sex and the younger age at initial infection for women" (UNAIDS, 1999).

Another characteristic of HIV in Africa is the impact it is having on the youth and productive age group as well as the growing number of orphans being left behind. Approximately half of the people with HIV are infected under the age of 25 and die before their 35th birthday. Even younger age groups are becoming infected in Sub-

Saharan Africa. This has a significant impact on the demographic profile of a country not to mention its labour force (UNAIDS, 2000d).

Studies in Africa reveal that girls aged between 15 to 19 years are five to six times more likely to contract HIV than boys the same age. UNAIDS has found that the infection rate in men eventually catches up but not until after they have reached their late 20's or early 30's (UNAIDS, 2000d). This is a significant factor and reaffirms the importance of identifying strategies and target interventions, which support girls' education in Africa.

1.2 Socio-Economic Factors and HIV/AIDS in West Africa

The following section explores some of the unique socio-economic problems ECOWAS countries face as they prepare preventive programmes to militate against the impact of HIV/AIDS. All ECOWAS countries except Cape Verde are categorised as low-income countries having the poorest GDP growth and economic indicators when compared globally. World Bank reports suggest that the gains in macroeconomic growth over the last decade will be reversed by the impact of AIDS (World Bank, 2000b). Table 2 summarises some of the key socio-economic indicators across the ECOWAS countries, which may have a direct impact on the prevention of AIDS and the spread of HIV/AIDS.

Table 2: Key Socio-Economic Data for West Africa according to prevalence of AIDS

Countries[5]	Adult Rate of HIV infection (%)[6]	GNP (Per capita US $	HDI[7] Rank	Adult Literacy rate (%) for 1995-99	Female literacy rate (%)	Life expect-ancy at birth	Under five mortal-ity rate (Rate)	Primary school enrolment ratio (1999)
Ivory Coast	10.76	710	144	50	30	47	171	71
Liberia	8.2	490	---	25	22	50	235	35
Burkina Faso	7.17	240	159	19	9	45	315	41
Sierra Leone	6.0	130	162	32	18	39	316	103
Togo	5.98	320	128	52	37	49	143	133
Nigeria	5.4	310	136	57	47	50	187	70
Benin	4.1	380	147	30	26	54	156	76
Mali	3.5	240	153	29	23	54	235	50
Ghana	3.0	390	119	64	54	61	101	79
Guinea Bissau	2.5	160	156	32	43	45	200	69
Niger	2.0	190	161	13	7	49	275	32
Gambia	1.8	340	149	31	25	48	75	72
Guinea	1.54	510	150	35	22	47	181	54
Senegal	1.4	510	145	51	23	53	118	66
Cape Verde	1.75	1330	91	85	64	70	73	131

(Based on UNICEF, 2001, State of the World Children and UNAIDS, 2000a)

[5] Countries are ranked in order of highest rates of infection among the adult population aged between 15 and 49
[6] Data Based on UNAIDS latest reports from the Inter country Team for West and Central Africa (August, 2001)
[7] The Human Development Index (HDI) is a quality of life indicator and includes information on education, health and income.

Table 2 reveals the low levels of literacy within ECOWAS countries. This is a significant factor when designing preventive programmes for populations. The challenge of arresting AIDS may be greater in countries with a low female literacy rate such as Burkina Faso (9%), Niger with (7%) and Sierra Leone with only 18% female literacy rates. These same countries are also among the top ten in the world with high levels of under five mortality rates. Niger and Sierra Leone come first and second consecutively in the world ranking (UNDP, 2000). Analysis reveals that almost all West African countries fall within the top 20 countries having the highest levels of infant mortality ranging from 64 to 161 for every 1000 live births.

All 15 ECOWAS countries fall within the 50 countries of the world having the highest under 5-mortality rate, suggesting a very poor quality of life for children and a higher level of vulnerability to HIV/AIDS. The relationship between poverty and HIV/AIDS is explored by UNDP, which suggests poverty is intensified in households and communities that experience HIV and AIDS. Households and communities under the poverty line are more vulnerable to contracting HIV/AIDS. Qualitative research from West Africa reveals that girls from lower socio-economic categories are more vulnerable to HIV/AIDS due to socio-cultural practices, and early marriage (UNDP, 2000). This is explored further in the coming sections.

Analysis of some key socio-economic indicators and HIV infection rates was carried out. Simple correlation analysis between literacy and adult rates of infection reveal a weak positive relationship between HIV/AIDS rate of infection and literacy (r =.17391). This analysis is based on ECOWAS countries still at their early stages of the HIV/AIDS epidemic. Much more research is needed to explore the relationships between socio-economic factors and HIV/AIDS using both quantitative and qualitative analysis.

1.3 Special characteristics of HIV/AIDS infection within West Africa

HIV 1 and HIV 2 are both prevalent within West Africa. The presence of HIV 2 is a unique characteristic of HIV/AIDS epidemic within the sub-region. The highest prevalence of HIV2 is found in Guinea Bissau, Gambia, Senegal, Ghana, Cote d'Ivoire and Burkina Faso (Wijermars, 1993)[8]. "HIV2 has been found in some other countries but often in people who have connection with West Africa" (Wijermars, 1993). Studies show that HIV 2 is less transmissible and harder to contract than HIV1. (Wijermans, 1993)

Another challenge facing countries within the West African region is the increasing destabilisation from civil strife and ethnic conflict. Sierra Leone, Liberia, Guinea and Cote d'Ivoire all face the presence of ethnic and civil strife. 11% of peacemakers returning from Sierra Leone and Liberia were HIV infected compared to 5% infection within the adult population (ICTWCA, 2001). The figures for South Africa are much higher with 60-70% of the military infected by HIV compared to 20% of the adult population. The major consequences of conflict are the increased vulnerability to the infection due to risk behaviour, sexual abuse and violence. In addition data is harder to collect which creates added difficulty in monitoring, tracking and implementing prevention programmes across West Africa. Recent studies suggest that the

[8] Confirmed by the UNAIDS Inter-country Team for West and Central Africa, Sibailly, 2001

transmigration of refugees will also be a growing source of HIV/AIDS transmission (World Bank/UNAIDS, 2000).

1.4 The Spread and Transmission of HIV/AIDS

The HIV/AIDS prevalence rates across West Africa are not on the same scale as that being experienced in Southern Africa. The highest adult rates within Sub- Saharan Africa are experienced in Southern Africa where rates of infection reach as high as 35%. The 1999 adult rates of HIV infection were as follows: Botswana with (35.80 %), Swaziland (25.%), Zimbabwe (25.06%); Zambia (19%) and Kenya with 13.5% (Kelly, 2001; UNAIDS 2000b). The incidence of HIV/AIDS is steadily increasing as depicted in Map 1. Table 3 represents the number of West African countries, which have reached a 5-10% infection rate of transmission over the last 15 years.

Table 3: The Spread of HIV/AIDS infection within West Africa

Year	Number and name of ECOWAS countries with over 1-5%		Number and name of ECOWAS countries with 5-10%		Number and name of ECOWAS countries with 10-20% rate of HIV/AIDS infection	
1984	**3**	Cote d'Ivoire Togo Burkina Faso	0		0	
1989	5	Togo Burkina Faso Benin Liberia Sierra Leone	1	Cote d'Ivoire	0	
1994	12	Benin Liberia Sierra Leone Ghana Guinea Bissau Guinea Gambia Senegal Nigeria Niger Mali Cape Verde	2	Burkina Faso Togo	1	Cote d'Ivoire
1999	11	(Same as above except Nigeria moved to next category).	3	Liberia Sierra Leone Burkina Faso Togo Nigeria	1	Cote d'Ivoire

(Based on UNAIDS, 2000 update)

1.5 Factors Affecting the Spread of HIV/AIDS

This section explores the factors affecting the spread of HIV/AIDS within West Africa. Determinants of the epidemic include: displacement, the breakdown of social structure such as family and community relations, suspension or absence of social control or risk behaviour. Piot, Goeman and Laga (in ECA, 1999) categorised the main factors influencing the spread of HIV/AIDS into five factors:

- Sexual behaviour
- Presence of sexually transmitted diseases
- Demographic variables
- Economic/ political parameters
- Population mobility

These are expanded in annex 1. UNAIDS breaks down the factors for 'kick-starting an HIV/AIDS epidemic into behavioural, social and biological factors. These are presented in Table 4.

Table 4: Factors related to the spread of HIV/AIDS

Behavioural and Social Factors	➢ Little or no condom use ➢ Large proportion of the adult population with multiple partners ➢ Overlapping sexual partners ➢ Large sexual networks (individuals moving between home and far off workplace) ➢ Age mixing, typically between older men and young women or girls ➢ Women's economic dependence on marriage or prostitution, robbing them of control over the circumstances of sex.
Biological Factors	➢ High rates of STD's especially those causing genital ulcers ➢ Low rates of male circumcision ➢ High viral load

(Based on UNAIDS Epidemic Update, 2000)

The Economic Commission for Africa (1999) argued that the demographic profiles of West African countries are conducive to the higher incidence of HIV/AIDS rates compared to developed countries. Another demographic factor is the skewed sex ratio of more males to females.

The study suggests that population mobility is a key factor in the spread and incidence of HIV/AIDS. Cote d'Ivoire is a case in point since it has a high level of immigration with about one quarter of its population (15 million) deemed as immigrants (1998 figures). It is also a country experiencing the highest rate of HIV/AIDS prevalence among the adult population within the sub region. The link between HIV/AIDS prevalence and migration was established in Ghana by Anarfi (1993) when studies revealed that over 86% of persons with HIV/AIDS had lived outside the country.

The ECA study identified the following locations as key foci for the spread of HIV/AIDS pandemic: commercial inland routes, big towns, mining towns and industrial centres. Persons who are highly susceptible to HIV/AIDS infection include prostitutes, truck drivers and international commercial and labour migrants. (ECA, 1999).

A study of HIV/AIDS in West Africa conducted in the early 1990's deduced a number of reasons for the spread of HIV/AIDS in some West African countries (Wijermars, 1993). Table 5 presents the findings.

Table 5: Suggested reasons for transmission across some ECOWAS countries

Country	Suggested reasons
Benin	➢ Migration (both seasonal and long term) particularly along the coastal areas due to the poor economic situation. ➢ Men were found to have sex with several partners while travelling and women were forced to have paid sex to support the family.
Burkina Faso	➢ 25% of the population is working abroad or in neighbouring countries. ➢ Seasonal and prolonged migration to neighbouring countries especially Cote d'Ivoire and Ghana enhance the rapid spread of the infection in the country. ➢ Burkina Faso is on the main West African trade route (Lagos, Niamey, Ouagadougou and Accra. ➢ A study in 1991 revealed annual incidence of STDs among Burkina Faso truck drivers was 43.3% ➢ Traditional practices such as excision and circumcision were also sited as reasons for the spread.
Ghana	➢ In 1992, 75% of the registered AIDS cases where among people infected with HIV outside the country particularly women who were engaged in the sex trade (i.e. Côte d'Ivoire)
Mali	➢ One factor contributing to the rapid spread of HIV in Mali is the migration, both seasonal and over longer periods of time, to Côte d'Ivoire.

(Based on Wijermas, 1993)

The high rates of migration on both a long and short term basis, the opening up of the ECOWAS countries to trade and increased integration suggest the need for a collective and unified approach to combating HIV/AIDS and preventing its increased spread. The next section will review some of the main impacts of the HIV/AIDS epidemic on different sectors of the society.

Migration patterns and mobility trends

The following section highlights some of the migration and mobility factors, which are causing the virus to spread in West Africa. The findings of the World Bank/UNAIDS (2000d) migration study deserve some mention since many of the socio-cultural causes of the HIV/AIDS transmission (World Bank/UNAIDS, 2000d) are revealed. The study used a unique approach of identifying ecological site specific areas to record behaviour and test interventions in countries including: Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal. Table 6 presents some of the key findings.

Table 6: Migration Trends and Patterns across ECOWAS countries

Types of migration	Examples of locations/activities where HIV/AIDS may be transferred	Examples of countries/locations in study[9]
Short Duration	➢ Traders or "Banabanas" (often single	➢ Dakar-Bamako express

[9] Please note that this is not an exhaustive list. The study did not mention all the countries where these practices are most likely taking place but provided qualitative data on a few case study sites. We mention the names here as an example.

Types of migration	Examples of locations/activities where HIV/AIDS may be transferred	Examples of countries/locations in study[9]
Migration	females living in precarious dwellings) ➢ Pilgrims to religious towns and villages ➢ Traders' travelling to weekly markets and stays a few nights. ➢ Social events in the life of rural communities (death, birth, weddings) ➢ Long distance truck drivers and passenger carriers ➢ Military and para-military personnel ➢ Sex workers having activities in mining and agro-industrial sites usually around paydays. Sex workers also frequent the markets, religious festivals, tourist sites and trans border networks.	➢ Mali ➢ Mali and Côte d'Ivoire ➢ **Sahelian Road axes** (Mainly Niger Burkina Faso and Mali heading towards Ghana, Togo and Benin) ➢ Niger, Côte d'Ivoire, and Mali ➢ Mali, Senegal and Côte d'Ivoire
Medium Duration migration (few weeks to months)	➢ Male and female merchants ➢ Agricultural labourers involved in seasonal migration ➢ Commercial sex workers and students	➢ Senegal to Mali, Burkina Faso, Gambia and Guinea or Mauritania ➢ Workers from Mali and Burkina Faso move to Côte d'Ivoire sugar factories, etc.
Long Duration Migration (several years)	➢ Agricultural activities ➢ Socio-professional activities by migrants in the host country (the sale of fabrics in Mali by people from Niger)	➢ Senoufo in Côte d'Ivoire and the Mossi from Burkina Faso
Prostitution	➢ "sex workers were found to travel a lot in order to attract new clients" ➢ Sex workers are found in Togo, Côte d'Ivoire and Senegalese sites but rarely in their own areas. ➢ Sex workers from Niger are also found along the Bamako and Abidjan Axis.	➢ Action Aid reported commercial sex workers in Burkina Faso are mainly from Ghana and Togo Senegalese based sex workers from Mali
High migration and Mobility areas	➢ Transport Stations ➢ Market Places ➢ Trains ➢ Neighbourhoods	

(Based on World Bank/UNAIDS, Migration and Aids study in Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal, 2000)

The study reveals that migration is associated with a multiplicity of sexual partners since people are far from their homes and have different social, religious and moral codes to guide their behaviour (OPTION: Insert map on mobility work see www.onsida-aoc.org for more information).

1.6 Vulnerable groups

Recent studies from the Ghana and other Sub-Saharan African Countries indicate that HIV/AIDS is having a significant impact on youth particularly at tertiary levels of education (Kelly 2001; Anarfi, 2000). Interviews conducted in the UNAIDS/World Bank study (2000) reveal that girls at university and secondary school often 'surrender themselves to a multiplicity of partners' due to their inability to meet their own basic needs. The following statements from girls' reveal some of the findings from this study.

BOX 1: Girls responses to HIV/AIDS in West Africa

" I am often afraid when men say that they prefer "plain flesh" contacts, but it can be so difficult to resist when one has pressing needs. So I just surrender, praying that God should protect me." (Young girl interviewed in Côte d'Ivoire)

" In this region, each girl is always trying to have one or several sexual partners among civil servants and mainly among military personnel: policemen, military men, constables, customs officers, etc. they are 'donors'" (Côte d'Ivoire)

" As far as students are concerned, we elaborate strategies to take hold of rich men and womanizers. We do not walk the streets, nor do we go to fetch men in hotels or bars… generally, we do not take men to our houses, we follow them to wherever they want to take us" (Female University Student, Dakar, Senegal, UNAID)

(Interviews conducted as part of the World Bank/UNAIDS, 2000 Migration study)

Most girls interviewed in the study were aware of the risk HIV/AIDS poses but were pressured to find ways to meet their basic needs such as food, clothing and books. USAID (1996) research on the socio-economic impact of AIDS suggests that "gender inequity of all kinds increases women's vulnerability to the HIV infection in three closely related ways. Inequality of men and women creates an environment where:

- Lack of economic opportunity for women leads to dependence on men
- Poor status and control of women over their own lives deprives them of their right to refuse sex
- Some cultural practices directly or indirectly lead to HIV infection

Mobile populations, migrant, sex and transport workers have also been labelled as "high risk" groups due to their engagement with regular suppliers or consumers of casual sex, whether in exchange or not for money. Areas, which are often locations for causal sex such as weekly markets and transport sites, are becoming increasingly targeted for prevention programmes. For instance, in Ghana the second major economic activity for women is itinerant trading where women live away from home for weeks at a time. A study on the risk of HIV suggested that female itinerant traders are highly vulnerable to HIV infection since they are mobile and away from their normal partners for extended periods of time (Bollinger, Stover and Antwi, 1999a). Sexual contact between truckers and "market women" along the road has also been deeply entrenched in the transport system in Nigeria making people in these professions deemed a "high risk" category to HIV/AIDS infection.

2.0 HIV/AIDS Prevalence across the West Africa

UNAIDS, WHO, and governments themselves have monitored the spread of HIV in Sub-Saharan Africa over the last 15 years. The following section will explore the

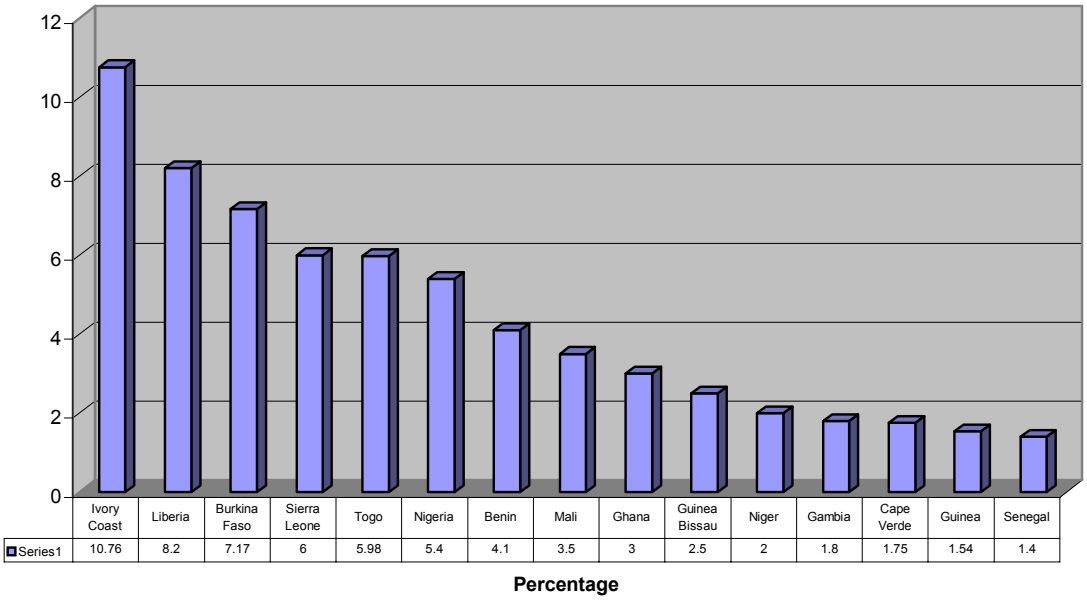
prevalence of HIV/AIDS across all countries within ECOWAS using gender and age disaggregated data.

2.1 Measured Adult Prevalence

HIV prevalence is measured according to the median, minimum and maximum prevalence among pregnant women attending antenatal care clinics in major urban areas. These clinics have been regularly surveyed in most countries since the early 1980's but there are some problems with the use of these indicators. "Antenatal estimates tend to underestimate the real level of HIV infection in women" (UNAIDS/ECA, 2000). Since women become less fertile the longer their HIV infection, the less likely they are to get pregnant and attend antenatal clinics where blood samples for anonymous HIV testing are taken.

Côte d'Ivoire, Liberia, Burkina Faso, Sierra Leone, Togo and Nigeria are among the countries with the highest prevalence rates. Figure 1 presents adult rates of infection across West Africa as of August, 2001 based on the ICTWCA reports.

Figure 1: Adult Rate of Infection in West Africa Countries



The five countries with the highest adult rates of HIV/AIDS infection are Côte d'Ivoire with 10.76%, Liberia with 8.2%, Burkina Faso with 7.17%, Sierra Leone at 6.0%, and Togo with 5.98% and Nigeria with 5.06%.[10] Data vary among studies. For instance a

[10] Adult rates include all the people with HIV infection whether or not they have developed symptoms of AIDS at the end of 2001. Adults refer to people between the ages of 15 to 49 and are the most sexually active age group. These figures relate only to HIV1 infection (UNAIDS, 2000)

study by the Futures group suggests that Nigeria's prevalence rate was between 8 to 10 % (Bollinger, Stover and Nwaorgu, 1999). Other UN studies suggest that Liberia is at 2.8% as of 2001 (United Nations, 2001). The Ghana National Strategy document (2000) reveals that the adult rate of infection is as high as 4.6 percent. This researcher used information provided by the UNAIDS Inter-country Team for West and Central Africa as the main source of data for prevalence rates since data was based on the most current and reliable sources (i.e. National AIDS commissions within West Africa).

2.2 Gender and Age Disaggregated Data

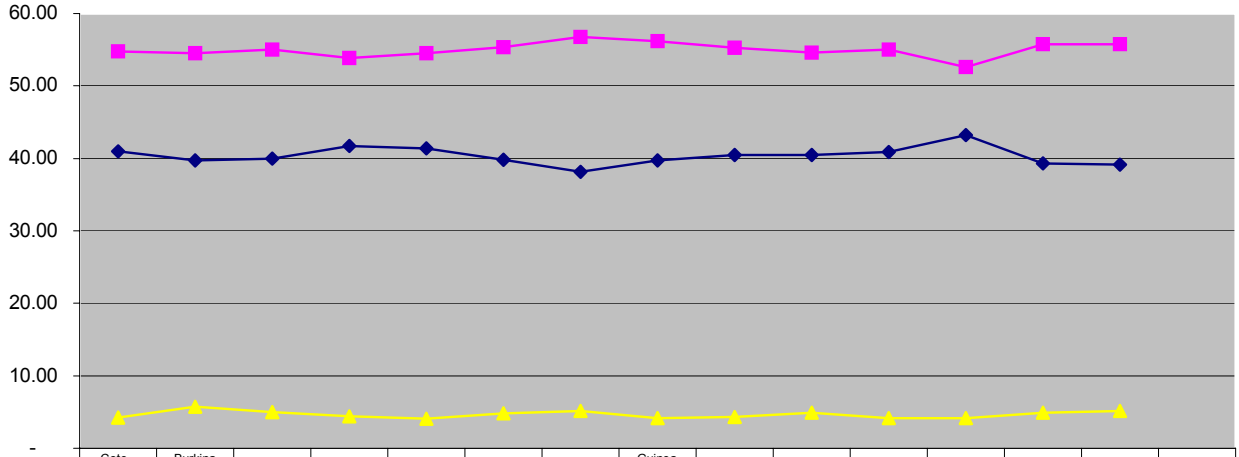
"The cultural constraints, the weak socio-economic and poor schooling status of women have the consequence of not enabling them to influence their spouses' or partners', even less to discuss sexuality with them… the messages developed for AIDS control are most of the time not adapted for women and inapplicable by them." (Marie-Rose Sawadogo, NGO representative, Burkina Faso in UNAIDS Best Practice Collection, 2000)

The following section is based on data from the ECA, 2000 Country-by-Country report and explores gender-disaggregated data in order to highlight trends among children and women. The percentage of HIV persons who are women ranges between 52.6% in Senegal to as high as 56.2% in Guinea Bissau. The average across ECOWAS is 55%. The percentage of HIV infected persons who are men range from a low of 38.12 % in Liberia to 43.21 in Senegal.

Surveillance studies from the National AIDS and Sexually Transmitted Disease Control Programme in Nigeria reveal that 20% of the current AIDS cases are civil servants, 18% are housewives and businessmen, 11% are farmers and 8% are students. The government sector in Nigeria will be highly affected by HIV/AIDS when employees begin to die (Bollinger, Stover, and Nwaorgu, 1999).

The Ghana National AIDS Control programme estimates that the number of AIDS orphans will increase to 160,000 by the year 2000 and 400,000 by 2010. Enrolment rates in schools are lower for orphans further impacting on the economy in the long run (Bollinger, Stover and Antwi, 1999). Approximately 184,000 children in Nigeria under the age of 15 became maternal orphans in 1997 (Bollinger, Stover and Nwaorgu, 1999). Figure 2 presents the main data for HIV rates among men, women and children across ECOWAS.

Figure 2: Gender and Age Disaggregated Data Based on Total HIV/AIDS Population
(UNAIDS/ECA, 2000, Country by Country Report)



	Cote - D'Ivoire	Burkina Faso	Togo	Nigeria	Ghana	Sierra Leone	Liberia	Guinea Bissau	Benin	Mali	Gambia	Senegal	Guinea	Niger	Cape Verde
% of men infected	41.01	39.74	40.01	41.74	41.38	39.78	38.12	39.72	40.49	40.46	40.85	43.21	39.29	39.13	
% of women infected	54.79	54.55	55.00	53.85	54.55	55.38	56.76	56.15	55.22	54.64	55.00	52.63	55.77	55.74	
% of children infected	4.20	5.71	4.99	4.41	4.07	4.83	5.13	4.13	4.29	4.90	4.15	4.16	4.94	5.13	

The percentage of HIV infected children range between 4 to 6% of the total HIV/AIDS population in West African Countries. Mother to child transmission remains high in these countries ranging from 25 to 45% in Africa (UNAIDS, 2000d; GRIA Conference see SAFCO, No.1 2001).

BOX 2: Mother to Child Transmission: a looming problem

Mother to Child Transmission (MTCT) remains a major concern for Sub Saharan Africa while most of the developed world has been able to eradicate MTCT. HIV infections caused by MTCT fell from 26% to 8% in 1994 in the developed world and are now at 1% with the introduction of drugs such as Anti retroviral drugs (ARU's). Paediatric HIV remains a serious public health problem in West and Central Africa.

- More than 3 million children are infected with HIV/AIDS --90% of children infected by HIV is due to MTCT.
- HIV/AIDS infection among women at the age of giving birth varies from 4 to 14% (across ECOWAS). Cote d'Ivoire has the highest percentage of MTCT.
- Rates of MTCT vary from 25% to 42% in developing countries and 1 to 25% in industrialized countries.
- Only a few countries within West Africa have taken steps to prevent Mother to Child Transmission.

(*Based on Regional InterAgency working group meeting on MTCT in West and Central Africa (GRIA), July, 2001)*

2.3 Rate of infection among sex workers

Analysis of the data across ECOWAS reveals an alarming trend regarding the rate of infection among sex workers. Table 7 presents the number of female sex workers between the 1980's and the 1990's infected by HIV/AIDS across West Africa.

Table 7: Rate of HIV/AIDS Infection among Sex Workers[11] in ECOWAS Countries

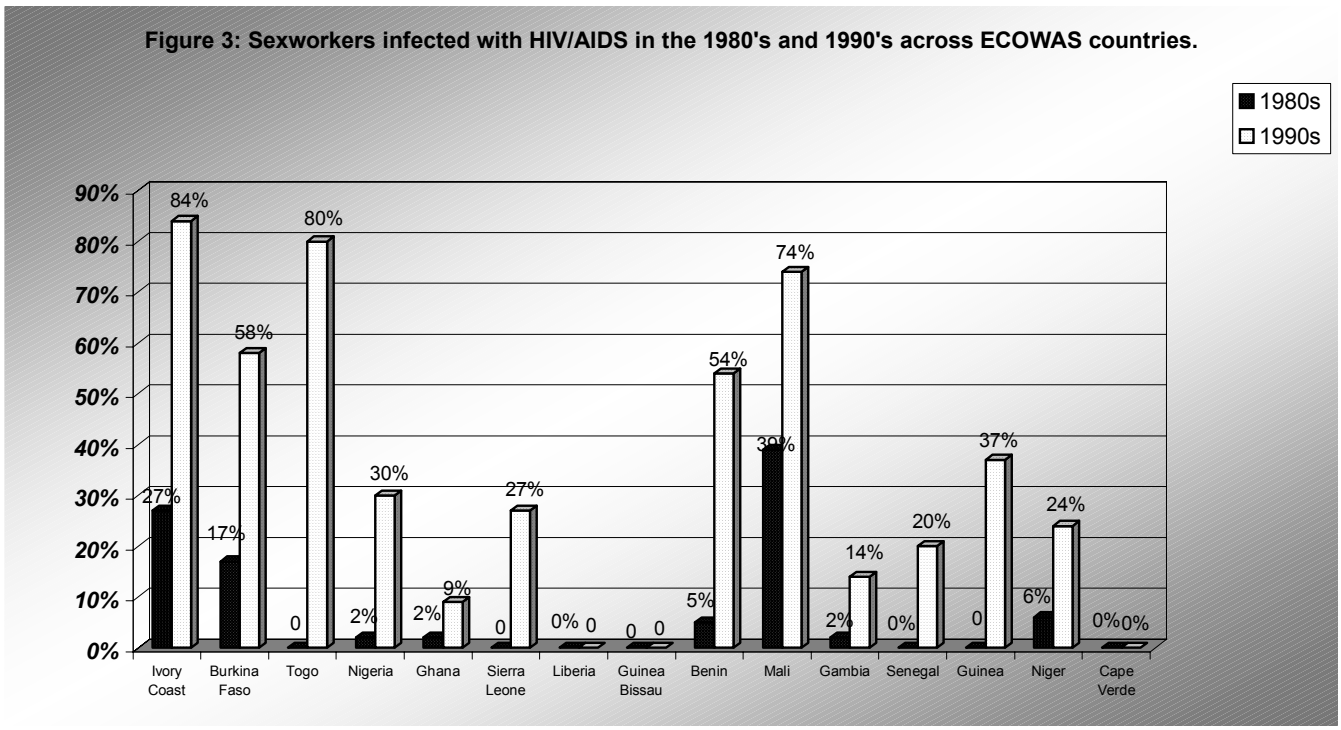
ECOWAS Country	Rate of HIV /AIDS infection amongst sex workers 1980's	Rate of HIV/AIDS infection amongst sex workers 1990's	Rank in terms of infection in 2000
Cote d'Ivoire	27% (1986)	84% (1992) 70% (1994)	1
Liberia	N/A	N/A	2
Burkina Faso	17 % (1986)	58% (1994)	3
Sierra Leone	N/A	27% (1995)	4
Togo	N/A	80% (1992)	5
Nigeria	2% (1988)	30% (1993/94)	6
Benin	5% (1987)	54% (1996)	7
Mali	39% (1987)	74% (1992)	8
Ghana	2% (1988)	98% (1991)[12]	9
Guinea Bissau	N/A	N/A	10
Niger	6% (1987)	24% (1997)	11
Gambia	2% (1988)	14% (1993)	12
Cape Verde	N/A	N/A	13
Guinea	N/A	N/A	14
Senegal	0% (1986)	20% (1998)	15

(Based on UNAIDS Country by Country report, 2000)

HIV/AIDS infection among sex workers in Côte d'Ivoire rose from 27% to over 84% in 1992/93. High transmission rates were also observed in sex workers in Burkina Faso, Mali and Togo although data are varied and in some cases not available. These countries also exhibit the highest rates of adult infection. Recent studies in Ghana suggest an increasing prevalence of HIV infection among sex workers. Deceuninck, Asamoah et al (2000) found that out of a sample of 335 female sex workers in Accra, 76.6% were infected with HIV (HIV-1, 62.3%; HIV-2, 4%; dual HIV1 and HIV2 profile, 10.3%). Figure 3 presents the prevalence rate among sex workers in 1980s and 1990s across ECOWAS countries.

[11] This is based on testing of sex workers in the urban centres of the country it does not include the sites located in the rural areas.

[12] A more recent study in Ghana found that close to 98% of urban sex workers are HIV positive.



Correlation analysis of the sex worker rate of infection compared to the adult rate of infection shows a strong positive relationship (r = .61397). This suggests that countries with high rates of HIV/AIDS infection amongst sex workers also have high rates of infection within their adult population. Data reveals that a high adult rate of HIV infection is associated with high rates of infection among sex workers (i.e. Ivory Coast, Burkina Faso, Togo and Nigeria). Figure 2.3 also reveals that there has been a significant increase in the rate of HIV/AIDS infection among sex workers between the 1980's and 1990s (UNAIDS/ ECA, 2000).

The focus of much debate over prevention and treatment of HIV/AIDS over the last ten years has been focussed on the professional and commercial sex worker industry. Some studies are beginning to reveal that a much larger undocumented population of women are involved in informal occasional or clandestine sex activities such as young university students who solicit for transactional sexual relations. One of the reasons for the high rate of HIV infection among sex workers and its relationship with the adult rate of HIV/AIDS is the issue of "transactional sex" according to the ICTWCA[13]. The phenomena of transactional sex is visible in studies by Anarfi and the UNAIDS mobility study which highlights the growing phenomena of girls selling themselves to "sugar daddies" who provide their basic needs in exchange for sex.

[13] Transactional sex is defined as the exchange of sex for comfort, goods or money, not necessarily on a professional basis (UNAIDS)

3.0 Impact of HIV/AIDS across ECOWAS Countries

There are very few studies concerning the impact of HIV/AIDS across the ECOWAS. The most comprehensive report appears in the Country-by-Country assessment by UNAIDS which is based on information submitted to UNAIDS for the African Development Forum in December 2000. A large body of literature has emerged concerning the impact of HIV/AIDS in southern and eastern Africa particularly in the agriculture and health sectors. This literature was reviewed in order to understand the potential impacts, which will face West African countries.

UNAIDS (2000) identifies several key indicators which help to analyse the impact of HIV/AIDS at the national, sectoral and community levels. Studies from other African countries were also used to supplement these findings. Table 8 presents a conceptual framework, which includes indicators used to analyse the potential impact of HIV/AIDS on a country-by-country basis.

3.1 Monitoring the Impact

The impact of HIV/AIDS across the West Africa and Sub-Sahara is characterised by a process of shock at national, local and household levels. Ainsworth and Over (1992) state that there is a 'network of interaction' between different sectors and actors and it is unreasonable to suggest that the impact of HIV/AIDS is independent of each sector. Table 3.1 summarises the basic indicators according to different sectors used by UNAIDS to monitor impact at micro and macro levels.

Table 8: Framework for exploring impacts of HIV/AIDS epidemic

Type of Impact	Specific indicators to consider
Demographic Impact	➢ Number of children in the country as of the end of 1999 having lost their mother or both parents to AIDS before age 14 from the beginning of the epidemic (UNAIDS, 2000) ➢ Number of adults and children who died of AIDS in 1999. ➢ Changes in the dependency ratio and in the age structure of a given country (long term indicator)
Macroeconomic Impact	➢ % Change of GDP growth over time and as a result of HIV ➢ Demand and supply of various services are affected
Sectoral Impact: ➢ Education	➢ Reduction in school enrolment due to child death, decreased fertility (demand) and higher demand on child labour ➢ Reduction in educational quality due to numbers of teachers absent and death due to AIDS (number of primary school pupils who have lost teacher to AIDS in 1999) (supply)
➢ Agriculture	➢ Reduction in labour force ➢ Percentage change in production ➢ Fall in labour productivity, crop yields and agriculture output ➢ Shift in production from cash crops to food crops ➢ Effect on Biodiversity
➢ Business/private sector	➢ Fall in the enterprise profits or increase in costs to the firms ➢ Higher levels of absenteeism ➢ Increased medical care payments and funerals ➢ Cost of worker replacement and training
➢ Health	➢ Share of hospital beds occupied by HIV positive patients

Type of Impact	Specific indicators to consider
	➢ Percentage of public health spending on AIDS prevention and care services ➢ Number of health professionals infected by HIV/AIDS ➢ Pressure on limited health personnel
Community Impact	➢ Socio-cultural impact in terms of loss of indigenous knowledge ➢ Shock to families and community due to loss of members ➢ Change of social and community practices
Household Impact	➢ Loss of productive hours ➢ Reduction of household savings and wealth (cost to the family) ➢ Diversion of scarce family resources away from education and food toward care for the sick ➢ Increase in AIDS related expenditures as a percentage of household income (Data is very limited at this level)

(Partially based on UNAIDS, Country by Country Africa Report, 2000 and Casely-Hayford, 2001)

UNAIDS/WHO working group has standardised a framework for collecting data on the status and trends of the HIV epidemic and patterns of risk and vulnerability in the population. This is compiled in their country-by-country report for Africa (UNAIDS/ECA, 2000). The Futures group has also compiled data on the economic impact in several West African countries. This is available from their web site at www.tfgi.com/hivaids.asp

Most existing data, which has been collected on a national basis and in relation to the economic impact of the HIV/AIDS epidemic, does not consider the social and cultural dimensions of the problem. More research is needed to identify potential social costs of the HIV/AIDS epidemic in ECOWAS countries particularly when considering the impact on households and children under the poverty line. The traditional welfare mechanisms, labour practices and the family unit as a whole will be threatened creating more burden on some social groups within the community. A growing body of evidence suggests that analysis, which is qualitatively oriented, can aid in the process of defining best practices and relevant interventions.

3.2 Situational Analysis of Impact across ECOWAS Countries

The following analysis is based on the most recent data from UNAIDS (2000a, 2000b, 2000c) across Sub-Saharan African countries. Many countries in ECOWAS are still yet to submit the basic data on the impact of HIV/AIDS. Table 9 presents a summary of information related to impact on macro and micro levels. Countries are analysed according to three categories: countries with between 1-4% HIV/AIDS infection rates, countries with 5-9% and those with rates as high as 10-20%.

Table 9: Macro and Micro impacts of HIV/AIDS across West Africa

Categories of Countries	Macro economic impact sited in UNAIDS report	Micro impacts sited in reports
1-4% of HIV/AIDS infection within the adult population (aged 15-49)[14] (11 out of 15 ECOWAS)	➢ Costs of financing the health sector in order to scale up AIDS programmes range from 1-3% of GDP (see annex 2)	➢ Household level impact and impact in the health sector

[14] Most ECOWAS countries fit into this category.

Categories of Countries	Macro economic impact sited in UNAIDS report	Micro impacts sited in reports
5-9 % of HIV/AIDS infection within the adult population[15] (Burkina Faso, Togo and Nigeria)	➢ Annual loss in GDP growth per capita as a result of AIDS will be .8% by 2010 (Burkina Faso) ➢ Annual loss in GDP growth per capita is .95% in Nigeria. ➢ Data from Togo are very limited.	➢ Family payments for the lifetime care of AIDS patient were between 416$ and 546 $ (two times the per capita income in Burkina Faso)
10-20% of HIV/AIDS infection within the adult population (Côte d'Ivoire)	➢ Macro Economic Impact estimate a loss of .8% GDP growth per capita as a result of AIDS (Bonnell, 2000)	➢ Dramatic impact of AIDS on the household wealth. ➢ Average household consumption falls from previous years ➢ Households with AIDS patients spend twice as much on medical expenses (Bechu, 1998) between 25-50% of annual net income is spent on AIDS patient

(Based on UNAIDS Country by Country report, December 2000)

The findings across Sub-Saharan Africa reveal that the impact is first felt at the household level and within the health sector particularly in countries having between 2-4% adult rates of infection. Countries with over 5% rates of infection experience larger scale impact with a decline in macro economic indicators such as GDP as HIV/AIDS infection rates increase. This trend was reported in the case of Côte d'Ivoire (UNAIDS/ECA, 2000). Data from countries in eastern and southern Africa also confirm this trend suggesting a profound impact on the macro level of the economy (UNAIDS, 2000d). Two major economic effects are a reduction in the labour supply and increased costs. The economic effects of HIV/AIDS will be first felt by individuals and their families, and then ripple outwards to firms and businesses and the macro economy. This is further explored in the following section.

Hancock et al. in USAID (1996) identifies several effects of the HIV/AIDS epidemic including the:

- Reduction in investment and savings due to higher health costs
- Decline in labour productivity due to work absenteeism
- Decline of labour productivity due to the loss of experienced workers
- Changes in labour market supply and demand
- Changing demand for Government services.

Hancock (1996) indicates that as the AIDS epidemic worsens with the increased spread of the disease, the economy is negatively impacted causing labour shortages and low levels of productivity. Ainsworth and Over (1992) analyse the impact of AIDS in terms of "shock and response" suggesting that AIDS in Africa is likely to have a greater economic impact than any other endemic disease due to the following reasons:

- AIDS affects primarily adults in their most productive years
- Both elite or high income workers and the low income workers are affected
- The long incubation period of HIV/AIDS means the impact is fully felt

3.3 The Economic Impact of HIV/AIDS

The loss of young adults in their most productive years will affect the overall economy not to mention the impact if economic elite are affected. The direct and indirect costs of AIDS also presents a burden to the family and the nation. If costs are financed out of savings a reduction in investment could lead to a significant reduction in economic growth (Futures Group, 2001).

There are several ways HIV/AIDS affects macro economic performance:

- Reduction of workers available and productivity reduced
- Shortage of workers leads to higher wages leading to higher production costs
- Lower government revenues and reduced private savings
- Reduced worker productivity and investment leads to fewer jobs in the formal sector

3.4 Impact at the household and community level

"At the community level as the HIV/AIDS epidemic deepens, the socio-economic impacts widen to affect the whole community, resulting in an adverse long term effect on the community structures and function. The loss of human resources affects all institutions (NGOs, CBOs) and community structures and these losses need to be planned for. Community problems that arise include the need to support an increasing number of orphans, reduced participation of the community in neighbourhood and community structures, increased homelessness and increased crime. In other words the social cohesion is threatened, a situation that in turn increases the risk of HIV transmission. " (UNAIDS, 1999b)

The following section explores the impact of HIV/AIDS at the household and community level. The household impact begins as soon as a member contracts HIV/ AIDS or a related illness. The impact is felt due to:

- loss of income,
- increased household expenditures
- absence from work or school when other family members care for the ill
- Death in the family will result in loss of income and future earning potential
- Loss of labour
- Funeral costs

Research from developing countries suggest that the main socio-economic impact of HIV/AIDS on households is the social, psychological and economic impacts. For a detailed listing refer to annex 3. The morbidity and mortality rates eventually change the demographic structure of the household and community. This has a devastating impact on smallholder farmers who often rely on their family members to sustain the family livelihood.

Ainsworth and Over (1992) indicate that HIV/AIDS mortality and morbidity shock the resource endowment at household level by reducing the time and labour available from household members. They also argue that HIV/AIDS reduces the human capital (education and health in a household) often resulting in a loss of land, housing and physical assets. The household ‘response’ to this shock includes the reallocation of time

of individual household members, decisions on production, expenditure, savings and investment. The combination of shock and response results in lower measures of well being such as: lower health status, lower educational attainment and over consumption per capita by members of the household. Educational opportunities are often reduced as children withdraw from school to care for the sick and reduced levels of nutrition have been found in poor HIV affected households.

Table 10 reveals some of the impacts at the household and community level based on UNAIDS Country-by-Country report (2000).

Table 10: Impact at household level within West Africa

Country in order of HIV/AIDS prevalence	Impact at household level
Burkina Faso	➢ Individuals and families will lose earning power as they face exorbitant medical costs that in turn diminish savings. ➢ Loss of wealth is exacerbated by the loss in revenues in the agriculture sector due to mortality and morbidity. ➢ Family payments for care of AIDS patients are between 416$ and 546$ equivalent to two times the per capita income in 1993.
Togo	➢ Illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns.
Ghana	➢ Extended family is likely to provide financial support when members are suffering from HIV/AIDS. Over 33% of the households surveyed reported receiving assistance from an extended family member. The study also found that families drew down asset holdings in order to pay for medical costs; 25% of households said they either borrowed or sold property for this purpose. (Bollinger et al., 1999a) ➢ Reports from the health workers in Eastern and Ashanti regions where the majority of AIDS cased are reported reveal that patients are unable to settle hospital bills because their life savings have been exhausted due to their illness.
Nigeria	➢ A case study of 25 households employed by one firm in Nigeria revealed that even though the company paid for medical expenses for the AIDS patients the family's source of livelihood was lost creating a major economic crisis. Social stigmatisation of those living with HIV/AIDS was very strong and gave rise to a negative psychological impact on the family.
Cote D'Ivoire	➢ According to the World Bank, Households with an HIV/AIDS patient spend twice as much on medical expenses compared with other households. 80% of the expenditures go to HIV/AIDS patients rather than other household members who are ill. When the HIV/AIDS patient moves away consumption levels fall by 44% during the following year (Futures Group International, 2001d) Study by the FAO found that 25% to 50% of annual net income of small farms when to male AIDS patients in the north and mid west of the country.

(UNAIDS/ECA, 2000 Country by Country report)

The FAO (1995) also reported on the social impacts of HIV/AIDS at the household level stating that the epidemic has:

- Threatened household food security
- Led to the break up of families (i.e. divorce) and children being sent to relations
- Led to a growing incidence of female and child headed households

- Changed the attitudes towards indiscriminate sex

The social impact of the disease has led to divorce whereby mothers and children move back to the villages where their own mothers reside. In the event of death, the children are split up and sent to different relations (FAO, 1995). The psychological impact on the families caring for HIV/AIDS patients is also significant. Often food and medical items are expensive and not affordable by families creating an added guilt and burden on the family. One study from Benin revealed that households reported that some traditions are breaking down and men are now waiting two or three years before marrying widows in order to determine whether the widows have HIV/AIDS. The widows often find it difficult to survive.

CIDA (1999) outlines the economic impact at household level. The economic impact at household level is illustrated in several ways. HIV/AIDS has impact on household finance through the following ways: high costs of caring for the individual living with AIDS depletes family savings, and reduces family expenditures on food consumption, health care and schooling for other members of the family.

Reports from Ghana suggest how infrastructure projects may increase vulnerability to HIV and demonstrate the impact on the household and community. The study also highlights the change in socio-cultural attitudes and patterns within society.

BOX 3: Impact of HIV/AIDS: Akosombo River Dam in Ghana

The Volta river Dam designed to provide hydro electric power was intended to provide hydroelectric power to the Accra-Tema region of Ghana. Although it attempting to solve some of the problems of the area and region the project area has been hard hit by the HIV epidemic in the last few years.

The Dam construction necessitated the clearing of 8.500 square kilometers and displaced some 80,000 farmers most of whom belong to the Krobo ethnic group. For the men the loss of arable land meant that they shifted to jobs and found work in the fishing industry or construction industry. For many women losing their only means of support: the land meant that many ended up in the hotels and bars to cater for the construction workers. Pushed to economic necessity many women resorted to prostitution.

When the dam was completed and the construction workers left, women migrated to other areas (Kumasi, Accra) and countries in West Africa (Ivory Coast) continuing to work as prostitutes and remit funds back to their families. Illegitimate children particularly girls born to young women during the construction boom learned to survive in the sex trade and found that their daughters followed their footsteps. HIV Seroprevalence survey sites within the rural Manya Krobo district (contained within the Akosombo area) found that HIV infection rates were five to ten times above the average for Ghana (between 1-4%). By the mid 1990s almost all the Ghanaian prostitutes in Cote' d'Ivoire were infected with HIV and returned home many to the Akosombo region.

The case highlights the complex nature of social upheaval on a community, which were displaced by the dam construction and the increased vulnerability it caused to HIV/AIDS.

(Based on FAO/UNAIDS, 1999)

This case presents insight into the personal and social trauma of HIV/AIDS caused by migration and stress on the family. The case demonstrated that indirect and long-term impact of the demographic changes exacerbated by the livelihood insecurity and gender inequalities for farmers who were displaced. The case highlights the vulnerability of women especially teenagers to HIV infection.

Poverty and HIV/AIDS

The vicious cycle of impact and increased vulnerability on poor families to HIV/AIDS are the subject of extensive research. This is explored in the next section.

" There are two sets of issues. One is that AIDS is causing and/or deepening poverty. The other is the combined effect of poverty and income inequalities on social transactions-including sex, patterns of vulnerability and patterns of risky behaviour in relation to HIV infection and AIDS." (UNAIDS, AIDS, Poverty Reduction and Debt: A tool kit for Mainstreaming HIV/AIDS Programmes into Development Instruments.)

UNDP's (2000) analysis of the poverty and HIV relationship suggests that the poor are more susceptible to the HIV/AIDS infection and there is an intergenerational impact on the family if education is not introduced particularly for the girl child. "Poor families have a reduced capacity to deal with the effects of morbidity and mortality than do richer ones."

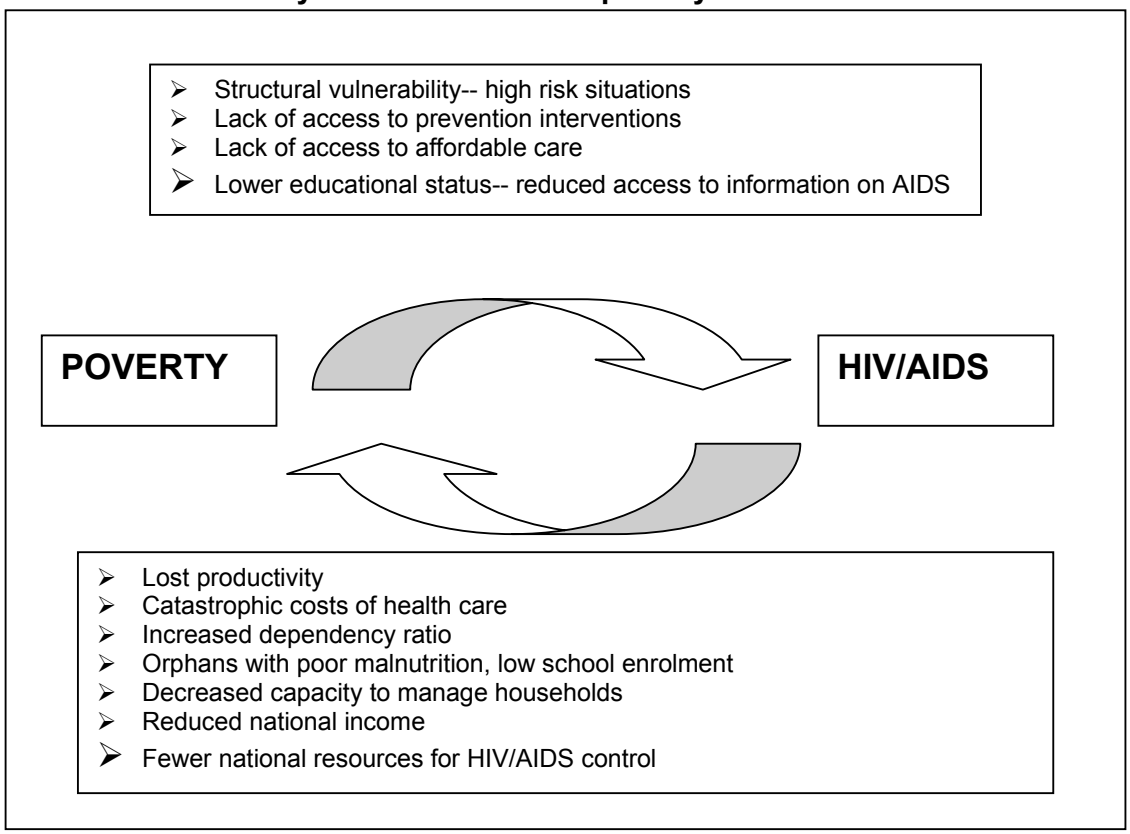
"Children's chances of escaping from their poverty depends on access to resources which are self evidently missing. These include access to education, which is the primary mechanism for social mobility. But education is one thing that these children will not have access to in accordance with their abilities (if HIV/AIDS becomes a factor) --- most evidently in the case of girl children" (UNDP, 2000). HIV/AIDS threatens to intensify the destruction of social, economic and cultural institutions which are currently being built up to sustain and enhance the next generation of children in Africa.

The UNDP (1998) study on the implications of HIV/AIDS for rural development across Sub-Saharan Africa reveals that the effects of HIV/AIDS on formal and informal rural institutions are profound.[16] Since the majority of the poor live in rural areas HIV/AIDS can:

- Further impoverish the affected person
- Erode the capacity of rural institutions due to the loss in human resources
- Disrupt the operation of rural institutions by severing the linkages in organisation and production

[16] Informal rural institutions include extended family and kinship groupings. While more formalised rural institutions include government departments, registered community based organisations, church groups, NGOs and the private sector at village and district level.

Box 4: The vicious cycle of HIV/AIDS and poverty.



(Based on UNAIDS, 2001b)

The HIV/AIDS epidemic threatens to "create a crisis of unprecedented proportions" particularly among the extended family and kinship systems, not only with the spread of HIV but also in relation to the viability of rural institutions and the traditional social safety nets to withstand the shock. Some of these traditional social safety nets such as widow inheritance and child fostering will become over burdened and in some cases break down.

3.5 Impact within the Education Sector across the ECOWAS Countries

Bollinger et al (1999) argue that AIDS affects the education in three main ways:

- The supply of teachers will be reduced by AIDS related illness and death
- Children may be kept out of school if needed at home to care for the sick or work on the fields
- Children may drop out of school if their families can no longer support their education

Kelly (1999) argues that HIV/AIDS affects the education sector in 10 broad ways:
(1) The demand for education; (2) the supply of education; (3) the availability of resources for education; (4) the potential clientele for education; (5) the process of education; (6) the content of education; (7) the role of education; (8) the organisation of schools; (9) the planning and management of the education system; and (10) donor support for education (World Bank, 2000c).

Three main indicators are used to analyse the impact in the education sector based on UNAIDS/ECA (2000) data: the supply and demand impacts on education, and the number of children infected by HIV. Research from southern Africa suggests that the HIV/AIDS epidemic will affect the demand for educational service moderately more than the supply until 2010 (Kelly, 1999). Table 11 summarises these factors:

Table 11: Measuring Impact in the Education Sector

Factor	Impact in the Education Sector
Demographic	Decline in size of school age population due to: ➢ High death rate among reproductive age lowering the fertility rate and population growth rate ➢ HIV/AIDS deaths among children ➢ Transfer of HIV to infants
Demand side	➢ Fewer resources for schooling children ➢ Reduction in the size of the school age population
Supply side	➢ Increased mortality particularly among teachers ➢ Increased absenteeism among teachers ➢ Increased unproductive work hours due to poor health
Potential clientele for education	➢ Number of children being orphaned as a result of the epidemic ➢ Increasing number of orphans
Educational planning	➢ Increased need for effective educational planning

(World Bank, 2000c, Exploring the implications of HIV/AIDS Epidemic for Educational Planning in Selected African Countries.)

UNAIDS and UNICEF (2000) have developed a model which tracks the mortality rates within the teaching profession and at school level. The mortality rates caused by HIV/AIDS have led to discontinuity within the education sector and increasing lack of teachers in some rural areas. The model also suggests that "increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household, is likely to erode the achievements in the areas of education, reducing enrolment and hence, literacy rates." (UNAIDS, Country-by-Country report, p.180). Table 12 presents the main results for countries where data was available.

Table 12: Impact on the Education Sector

Country in order of HIV/AIDS prevalence	Impact on the Education Sector (based on the number of teachers who may die from HIV/AIDS) (Based on UNAIDS/UNICEF modelling in 2000)
Côte d'Ivoire	➢ In 1996/97 64% and 70% of teachers' deaths were HIV related ➢ Out of a sample of 1.7 million primary school students at least 23000 are estimated to have lost a teacher to AIDS in 1999 (approximately 1.35%)
Burkina Faso	➢ Out of 700,000 primary school children 7400 would have lost a teacher to AIDS in 1999 (% 1.06)
Togo	➢ Out of a sample of 830,000 children, 7300 would have lost a teacher to AIDS. (% 0.88)
Nigeria	➢ Out of 14.8 million primary school children 85000 would have lost a teacher to AIDS in 1999 (% 0.57)
Ghana	➢ Gains made in enrolment will decline with the HIV/AIDS infection
Sierra Leone	➢ Increasing numbers of orphans and children's growing responsibilities as a consequence of AIDS in the household will lead to reduced enrolment and hence lower literacy rates.

Country in order of HIV/AIDS prevalence	Impact on the Education Sector (based on the number of teachers who may die from HIV/AIDS) (Based on UNAIDS/UNICEF modelling in 2000)
	➢ A model developed by UNICEF suggests that from a cohort of 420,000 primary school students, 1900 have lost their teacher to AIDS in 1999 (0.45%).
Benin	➢ Out of 750,000 primary school students, 1800 have lost a teacher to AIDS in 1999 (0.24%).
Mali	➢ Out of a total of 780,000 primary school students, 2000 have lost their teacher to AIDS in 1999 (0.26%).
Senegal	➢ Out of 900,000- primary school pupils at least 2000 are estimated to have lost a teacher to AIDS (0.22%) in 1999.
Gambia	➢ Out of 140,000 primary school students, 353 have lost a teacher to AIDS in 1999 (0.25%).
Guinea	➢ Current gains in enrolment of 46% could be reduced through HIV/AIDS ➢ Out of 650,000 primary school pupils, 1300 have lost a teacher to AIDS in 1999 (0.2%).
Niger	➢ UNAIDS/UNICEF (2000) of 480,000 primary school pupils 820 lost a teacher to AIDS in 1999 (approx. 1.7%)

(Based on UNAIDS/ECA, 2000 Country by Country report)

Table 12 reveals that between 0.2% to 1.7% of primary school pupils have lost a teacher to AIDS based on UNICEFS modelling exercise. The impact is higher in countries with higher rates of infection. Studies in Cote d'Ivoire reveal that children were withdrawn from school due to lack of finances for paying school fees and because children were needed on the farm. Where children were orphaned by HIV/AIDS, they were withdrawn immediately from school (Futures Group, 2001d). Studies in Cote d'Ivoire reveal that by 2003 using the low prevalence scenario, there will be close to 375,000 orphaned children due to HIV/AIDS.

Children Affected by HIV/AIDS

UNAIDS uses the number of children dying of AIDS and the number of children who have become orphans due to AIDS as key indicators to track impact within the education sector. Apart from Nigeria, the number of orphans has not yet reached the large numbers experienced in southern Africa but this will change once the adult rate of infection increases. Data was not available on the number of children who have died from AIDS over the last few years across West Africa. Figure 3.1 presents data on the cumulative number of orphans and the number of orphans currently living in West African countries.

Figure 4 indicates that Nigeria has the highest number of children currently living as 'AIDS orphans' followed by Côte d'Ivoire Sierra Leone, Liberia and Burkina Faso. These countries also have the highest rate of adult infection.

According to UNICEF (2001) 90% of the worlds orphans live in Sub Saharan Africa. In some African countries more than 10% of the children under 15 are orphans. In 2001 there were over 13 million children who had lost their mother or both parents to the HIV/AIDS pandemic. 90% of these orphans live in Sub Saharan Africa (UNICEF, 2001)

"The age and sex patterns of the disease including the high rates for women and middle age persons have and will have an impact on the ways care giving for children and the elderly are arranged in West Africa. In West Africa where formal orphanages are

Figure 3.1: Children affected by HIV/AIDS as of 1999
UNAIDS/ECA Country by country report

	Ivory Coast	Burkina Faso	Togo	Nigeria	Ghana	Sierra Leone	Liberia	Guinea Bissau	Benin	Mali	Gambia	Senegal	Guinea	Niger
Children (0-14) with HIV/AIDS	32,000	20,000	6,300	120,000	14,000	3,300	2,000	560	3,000	5,000	520	3,300	2,700	3,300
Cumulative Orphans	420,000	320,000	95,000	1,400,000	170,000	56,000	31,000	6,100	22,000	45,000	9,600	42,000	30,000	31,000
Currently Living Orphans	287,269	211,503	62,857	971,472	119,410	36,456	20,337	4,194	16,741	32,171	6,076	29,023	21,037	21,740

virtually absent the extended family, the traditional mechanisms for looking after children and the elderly will be overburdened, resulting in low quality assistance. (ECA, 1999)" Not to mention the impact HIV/AIDS will have on child poverty rates and the inability of children to continue in formal school systems and access basic health care services. Where a growing number of children sub Saharan Africa are both affected and impacted by the HIV/AIDS pandemic, many who are already under the poverty line will be pushed to a deeper level of poverty -- what is referred to as "hard core poverty."

Ghana: Child mortality rates will increase instead of decline in countries unable to control mother to child transmission. Ghana was set to reduce child mortality from 51/1000 live births by 2010. Child mortality is projected now at 75/1000 live births (Bollinger, Stover and Antwi, 1999a)
Nigeria: In Nigeria, infant mortality was projected to increase by 75% by the year 2000 due to AIDS and child mortality was expected to increase by 100 % (Bollinger, Stover and Nwaorgu et al, 1999).

3.6 Impact in the Health Sector across ECOWAS countries

This section presents the main impacts on the health sector. The health sector, similar to the education sector, will experience changes in the supply and demand of services to various clients. This is already the case in several countries such as Côte d'Ivoire, Liberia, Burkina Faso, Sierra Leone and Togo where the rates of HIV/AIDS infection among adults is between (4-10%) and the number of beds being used for HIV/AIDS patients is increasing. Burkina Faso and Ghana report that over 50% of bed occupancy was due to HIV/AIDS related illnesses. Other impacts in the sector will include the rising costs of financing the health sector for both preventive and treatment programmes. The World Bank estimates for financing health sector programming for prevention and treatment vary across countries ranging between US $4 million to as

high as $54 million US dollars per annum in countries with high levels of HIV/AIDS infection (i.e. Côte d'Ivoire). Costs to scale up programmes in Nigeria range from US $229 million to US $339 million dollars. Increasing demands on health care services and trained health care workers will be experienced in countries dependent on hospital-based programmes. Community based approaches may reduce the demand for professional medical assistance for care and prevention of HIV/AIDS infection.

The impact on the health sector is measured by the number of beds occupied by patients, and the costs to government in scaling up HIV/AIDS programmes. Other information was not available across the ECOWAS. Table 13 summarises the main impacts of HIV/AIDS on the health sector.

Table 13: Impact on the Health Sector across ECOWAS countries

Country in order of highest levels of HIV/AIDS prevalence	Impact on the health sector delivery (Demand)	Costs to the health sector (Scaling up HIV/AIDS programmes to meet current need)
Côte d'Ivoire	➢ Over 41% of beds are occupied by patients with AIDS related illnesses. ➢ By 1997, AIDS related costs absorbed 11% of the total public health budget. ➢ Cost of treating an AIDS patient in Abijan was about US $ 600 in 1997 (Futures Group, 2001d).	➢ Scaling up AIDS programmes will cost in the range of US $2 to 3.5 per capita and .5% of GDP (approx. 34 million to 55 million dollars per year) ➢ A total of US $ 20.3 million was spent in Cote D'Ivoire in 1995 on AIDS related interventions. 92% of this was spent on treatment and made up 6.8% of total health expenditure in the country (Futures Group, 2001d).
Burkina Faso	More than 50% of hospital beds are occupied by those with AIDS related illnesses	➢ Annual costs of scaling up HIV/AIDS programmes are between US $ 37 million and US $ 57 million.
Togo	➢ Increasing demand on the health sector due to HIV/AIDS	➢ US $ 10 million to 14 million needed to scale up HIV/AIDS programming ➢ (Approx. US $ 2-3 per capita and 0.9% of GDP)
Nigeria	➢ 1-2% of teaching hospital beds are occupied by AIDS patients ➢ The cost of treatment is about US$ 600 per month	➢ Large gap in funding (between US $ 229 - 329 million) to scaled up care and/or HIV/AIDS prevention programmes ➢ Costing between US $ 2 to 3 per capita and .8% of GDP.
Ghana	➢ Ministry of Health estimates AIDS related bed occupancy at 50% in 2000 and over 90% in 2010.	➢ Large gap in funding is needed to scale up programmes (US $ 55 million and US $ 87 million)
Sierra Leone	No information available	➢ US $ 9 million to 14 million (Approx. 2-3 dollars per capita and 1.8% of GDP)
Liberia	No information available	No information was available on impact
Guinea Bissau	No information available	Annual cost of scaling up is between US $ 4 million to 5.5 million (about .03% GDP).
Benin	One set of projections estimate that where prevalence reaches 10% of the population, 20% of	Large Gap in funding to meet the HIV/AIDS programming needs is 12 to 18 million U.S dollars. In 1995 a model

Country in order of highest levels of HIV/AIDS prevalence	Impact on the health sector delivery (Demand)	Costs to the health sector (Scaling up HIV/AIDS programmes to meet current need)
	hospital resources would be used by the year 2025. Where prevalence rates are 20%, the number increases to 38% of hospital resources. (Futures Group, 2001a)	showed between FCFA 97 million and 448.3 million is needed.
Mali	Rising infection rates in health care workers will impact on the supply of services	Annual costs of scaling up are estimated at between US $ 20 million to 30 million. This is equivalent to US $2 per capita or 1.2% GDP.
Gambia	No information available	US $ 7-10 million needed to scale up HIV/AIDS programmes Or 2.5% of GDP.
Senegal	No information available	Annual cost of scaling up HIV/AIDS programmes to meet the current need ranges from US $ 30-50 million. This represents approx. US $ 3-5 per person or 1.1% of GDP.
Guinea	No information available	US $ 25 million to 36 million needed to scale up programmes, approx. .9% of GDP
Niger	No information available	US $ 26 million to 36 million needed to scale up (1.9% of GDP).
Cape Verde	No information available	No information available

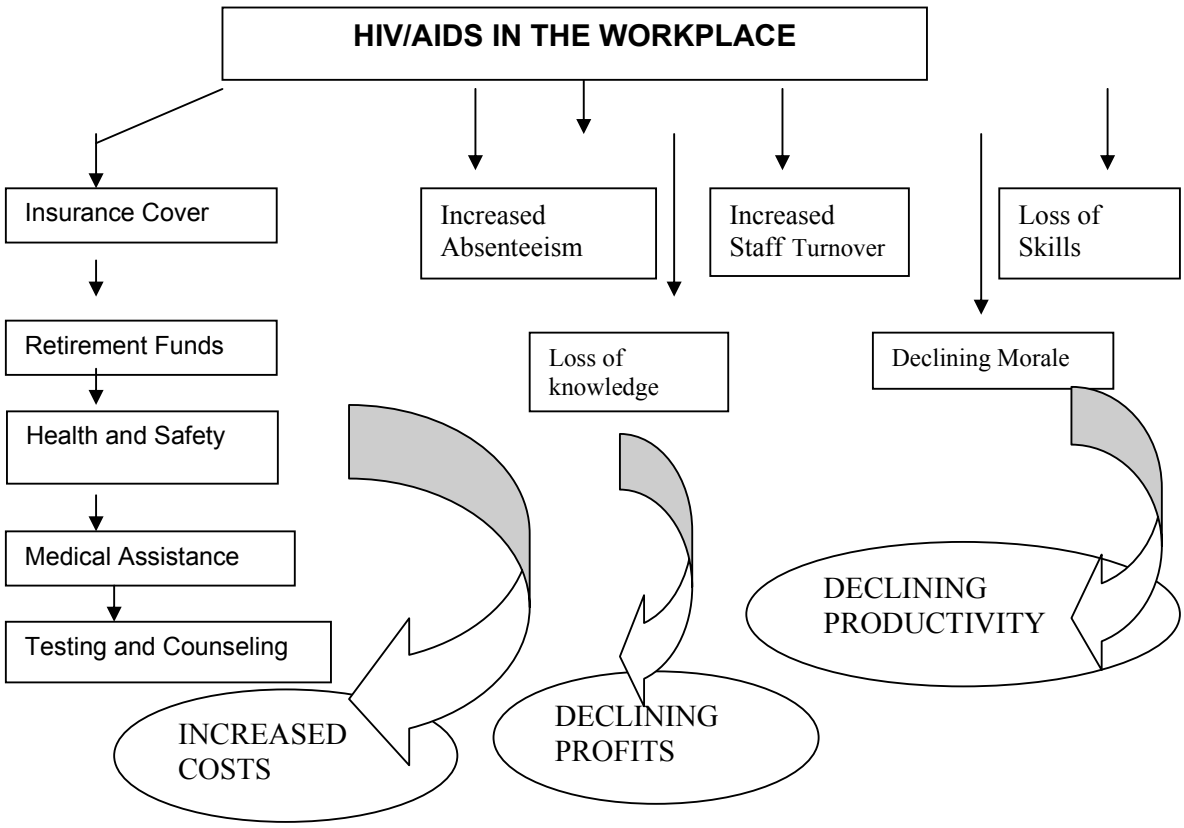
Studies in Nigeria also reveal that households caring for persons living with HIV/AIDS do not have the basic hygienic environment required for their care. Other evidence suggests that the extended family often sell off assets in order to pay for treatment (Bollinger, Stover and Nwaorgu, 1999)

3.7 Impact on the Private Sector across the ECOWAS Countries

The following section reviews the impact in the private sector. The HIV/AIDS epidemic will have increasing impact on households and firms. CIDA (1999) reports on the economic impact of HIV/ AIDS indicate that productivity in the manufacturing and resource sectors are affected by labour shortages, and high costs in training replacement staff. The tourism sector is also affected through the reduction in demand due to the negative perceptions of people towards countries with high rates of HIV/AIDS infection. Companies that provide employee benefits such as insurance, sick leave and funeral costs may find themselves having to revamp their employee benefits due to the high costs, reduced profits and productivity. Companies buffering losses due to HIV/AIDS among employee's leads to decreased investments and capital base.

Ainsworth and Over (1992) suggest that the firms are affected in the following ways: increased sick leave, higher worker turnover, loss of highly skilled managers, increased training costs, and increased expenditures for death and health benefits. Box 5 highlights the main impacts due to HIV/AIDS.

BOX 5: The Impact of HIV/AIDS on Companies (UNAIDS, 2000)



(Based on UNAIDS)

The following information was available from the UNAIDS/ECA Country by Country assessment (2000).

- Evidence in Côte d'Ivoire suggests that the annual average losses cost firms between .8% to 3.2% of the wage bill in 1997. Another survey of four businesses found that between 146 million and 298 million FCFA were spent on medical costs in 1993 (ECA, 2000). Studies in Cote D'Ivoire suggest that the largest costs for firms affected by HIV/AIDS relate to: medical care, lost productivity and funeral costs

although the share of each component will vary across different firms. Annual average costs per employee ranged between US$ 29 to US $ 125 among three companies in Cote D'Ivoire.

Indirect costs included: the interruption of teamwork, low productivity due to refusal of employees to eat with fellow workers who were HIV positive. Workers were also suspicious of medical confidentiality and whether employees were being unfairly dismissed. Organisational and work structures were reorganised when key managers and other personnel died by forming more flexible work teams (Futures Group International, 2001).

- Studies in Benin indicate that the HIV/AIDS epidemic is inflating costs for business. "In a 1998 survey of employees in 14 firms, AIDS was found to increase costs in six of these firms, and lead to a decrease in profits for the remaining eight." A loss of savings, a reduction in hours at work and in some cases bankruptcy was the result.

Company moves forward in the fight against HIV/AIDS

Chevron Nigeria Ltd has been running education and prevention programmes for their employees over the last five years. Chevron is one of the largest integrated petroleum companies in the world and has been operational in Nigeria since 1961. In 1997 the company sought to address the problems of HIV/AIDS due to the recognition that HIV/AIDS could have an enormous impact on its workforce and business. Surveys revealed a high level of ignorance and misconception about the disease, the presence of sexual networking at oil locations, high levels of sexually transmitted diseases; and a high level of risk among the mobile workforce.

The company engaged in a range of HIV/AIDS education activities after some research and tailored activities to meet the needs of different groups particularly the field based workers, local communities and commercial sex workers. A wide variety of HIV/AIDS workshops campaigns and youth clubs were launched using drama, songs, poetry and music. The labour union was also involved in supporting management efforts. The multi-pronged approach proved cost effective through reducing the health costs to the company and investing funds for designing in-house materials. Other results of the programmes included: increased condom usage, increased demand for counselling, reduction in prejudice and discrimination against people with HIV/AIDS. The company was also able to actively engage the labour unions and local community in combating the HIV/AIDS pandemic. The case highlights the need to lobby and educate senior management within a company along side labour unions in order to mobilise the workforce in the fight against HIV/AIDS (UNAIDS, 2001 "The Business Response to HIV/AIDS: impact and lessons learned").

Several companies in West Africa have not yet woken up to the fact that HIV/AIDS is on the horizon. Studies from Senegal and Ghana suggest that companies are not fully aware of the impact that HIV/AIDS will have on their company. Three firms in Senegal found that the management did not think there was any great risk of HIV/AIDS on their businesses (Bollinger, Stover, Antwi, 1999). In contrast a case study involving 14 firms, employees and their families in Benin found that families adopted some coping

strategies but the personal costs were tremendous with illness, depression, loss of interest in sex and living, loss of income and loss of social life.

3.8 Impact on the Agriculture Sector across the ECOWAS Countries

A general trend across most Sub-Saharan African countries reveals that the main impact of HIV/AIDS on the agriculture sector includes: increasing costs and expenditures, reduction of savings and shifts in productivity due to labour losses. A FAO (1995) study suggests that in countries, which are dependent on labour intensive agriculture for subsistence and cash crop production, the effects are becoming more pronounced. The impact is due to the direct costs to the farmers caused by medical and funeral costs and the indirect costs due to the labour shortages. For instance, the FAO study reveals that where household cash and labour flows are diverted to AIDS patients, less financing is available for purchases of fertiliser and investments in off farm activities.

The FAO (1995) study also found that the impact of HIV/AIDS were age and gender specific. Considering that women carry the bulk of the farm workload in a large part of Africa, and are also the most at risk, the study found that the epidemic has significant implications for agricultural labour. Many households experience labour shortages in households affected with HIV/AIDS. The direct impact of the epidemic on crop production was also observed in terms of a reduction in the land area under cultivation and a change in cropping patterns. The study argues that there have been substantial reductions in land use in many of the communities studied, especially in areas hard hit by HIV/AIDS. Food security at household level becomes an increasing problem. Table 14 presents some of the impacts reported in two ECOWAS countries.

Table 14: Impact on the Agriculture Sector in some ECOWAS countries

Country in order of HIV/AIDS prevalence	Impact on Agriculture
Côte d'Ivoire	➢ Shifts in production patterns from cash crops to food crop farming Leading to production at only 2/3 of previous levels (Black-Michaud, 1997) ➢ One mechanism to cope with impacts of HIV/AIDS within rural households is to reduce the amount of land under cultivation due to labour shortages experienced from increased morbidity and mortality. ➢ Crop sharing method is another mechanism to cope with labour shortages; although the same amount of land is cultivated, the owners receive only two thirds of the production. (Futures Group, 2001)
Burkina Faso	➢ FAO 1997 study found shifting work patterns and an overall reduction in food production due to AIDS at household level. ➢ Same study found a 25-50% decline in net revenues from agriculture production

(Based on UNAIDS/ECA Country by Country report, 2000)

Studies in Burkina Faso reveal the multi dimensional impact of HIV/AIDS on the agriculture sector. For instance a study by the FAO (1997) revealed that the treatment of AIDS patients demanded sacrifices of fowls and other small livestock by traditional healers. This was found to affect the food security of the household since families often use these animals for bartering for foodstuffs during times of shortage. Another study by FAO found that remittance income was interrupted due to HIV/AIDS. There was a breakdown of traditions, disorganisation of the family unit and young inexperienced farmers took over the control of the farms. Coping strategies including drawing down on savings, selling animals and pursuing other income generation activities became more common (Futures Group, 2001).

The FAO (1997) found that the incidence of HIV/AIDS resulted in the reduction in the production of market gardening, cash crops in some of the provinces. Farmers work patterns changed in order to balance the needs of HIV/AIDS patients with needs of the farm; for instance, when patients were very ill, fields near the home were worked in order to care for the sick patient. Significant reductions in food production were also experienced, and declines in net revenue of between 25 to 50% were experienced.

An ethnographic study conducted in 1996 found that families responded differently to AIDS patients depending on their economic status, the composition of the family, the fear of contagion and fear of gossip. Medical care for patients in rural areas of Burkina Faso where found to be nonexistent (Futures Group, 2001)

The next section explores the Government responses to the HIV/AIDS epidemic across West Africa.

4.0 International Responses and Appeals

4.1 The Leadership Commitment

The commitment to combating the spread and reducing the impact of HIV/AIDS has been debated in several conferences over the last year including the: Africa Development Forum (December, 2000), the Heads of State Conference on HIV/AIDS in Abuja, Nigeria (April, 2001) and finally, the UN Special Session on HIV/AIDS in June 2001. These conferences highlighted the important role African leaders play and the political will require for combating HIV/AIDS in sub Saharan Africa.

Box 6, 7 and 8 highlight some of the key conference outcomes.

BOX 6: Recommendations from the African Development Forum, December 2000 Addis Ababa Conference

The key conclusions from this forum emphasised the need for **political will, advocacy and leadership** at all levels to prevent the devastating impact of HIV/AIDS. Personal, community, national, and regional leadership as well as international partnership were emphasised in order to confront the HIV/AIDS pandemic, which has devastated so many countries in Sub-Saharan Africa. The key conclusions from the African Development Forum, on the **national leadership** front, include:

- National leaders should take prime responsibility to mobilise communities across the country "with commitment comparable to mobilising a war."
- National efforts should be made to scale up and replicate existing programmes and commit domestic resources to HIV/AIDS
- National strategies should include scaling up resources to provide medicines and anti-retroviral vaccines as soon as possible.
- Women must be involved in all components of HIV/AIDS programming. "Inequitable gender relations and opportunities lie at the core of the HIV/AIDS pandemic." The fostering of more female leaders is an important component of overcoming HIV/AIDS.
- "National AIDS institutions and councils should be strengthened as a matter of urgency in order to assure a broad, multi sectoral response at national and community levels."

BOX 7: Abuja Framework for Action, April, 2001:

African Heads of State Agreed to:

- Devote 15% of their annual national budgets to spending on health sector to helping address the HIV/AIDS epidemic.
- Set Up 10 billion dollar fund to combat HIV/AIDS in Sub Saharan Africa

Some of the priority areas for intervention included:

- Leadership at national, regional and continental levels to mobilise society
- Improvement of Information, Education and Communication (IEC)
- Protection for Human Rights
- Access for treatment, care and support
- Access to affordable drugs and technologies

(For more information contact **www.oau.org**)

BOX 8: Some of the commitments and recommendations from the UN Special Session on HIV/AIDS, New York, June 25 -27, 2001

Governments must ensure that:

- Strong leadership at all levels is essential for an effective response
- Development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS are ready by 2003.
- Regional organisations and partners are actively involved in addressing the crisis.
- Support greater coordination of all relevant UN organisations
- Establish time bound national targets by 2003 to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young people by 25 %
- Enact strengthen and enforce legislation, regulations and measures by 2003 to eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups
- Empower women to reduce vulnerability through prevention programmes especially for girls and boys within the formal education system.

(See www.unaids.org for more details on the special session)

The common conclusions reached from these conferences include the need for more democratic sustained leadership by the highest levels of Government in combating the HIV/AIDS pandemic. Government strategies should include action, which will influence individual choices, ease social constraints to safe behaviour, and set government priorities for preventing HIV/AIDS.

A strong political commitment in the fight against AIDS is important for several reasons since it:

- encourages an open approach to AIDS that helps reduce the stigma and discrimination that often hamper prevention efforts.
- facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority
- signals to individuals and communities involved in prevention that their efforts are appreciated and valued
- ensure that HIV/AIDS programmes receive the full support of national and international donor resources

Multi-sectoral leadership requires that every sector be involved in the planning of HIV/AIDS strategies. Annex 10 outlines the main recommendations across the sectors from the African Development Forum. By the end of 2001, each country is expected to have a national AIDS Commission and a strategic plan backed by legislation, modalities and mechanisms for monitoring.

4.2 Regional Responses to HIV/AIDS in West Africa

The following section outlines the major regional strategies and initiatives, which have been guiding HIV/AIDS prevention, control and management in the sub region. The section will review many of these initiatives and strategies supported by agencies in a number of sectors under the UNAIDS[17] umbrella. There are several strategies underway across the sub region to tackle the pandemic these include:

- Mother to Child Transmission (MTCT)
- Mobility and migration programmes to combat HIV/AIDS
- Debt and Poverty initiatives
- HIV/AIDS Surveillance

Mother to Child Transmission: A Regional Response

" The prevention of Mother to Child transmission should be the first entry point for HIV/AIDS prevention since it addresses issues of poverty, and gender inequality"
Toussaint Sibailly, UNAIDS ICTWCA

One of the strongest regional responses is related to the prevention of mother to child transmission (MTCT). The Inter-Agency Regional group for the Prevention of Mother to Child Transmission in West and Central Africa (GRIA) was created in December 2000. The objectives are to:

- Develop and adapt strategic objectives for the prevention of mother to child transmission
- Facilitate collaboration between the different partners
- Establish selection and harmonise the MTCT protocols implemented in the sub region
- Sustain the implementation of simple and effective strategies
- Set up and extend existing partnerships with other active organisations
- Collect, analyse and disseminate information on MTCT research programmes

Despite the availability of anti retroviral drugs (ARVs) for the reduction of MTCT of HIV the infection remain a public health problem in West and Central Africa. HIV/AIDS infection prevalence among women at childbearing age varies from 4% to 14% and the rate of mother to children transmission varies from 25 to 42%. Only a few countries within the region have taken steps for the prevention of mother to child transmission. In July 2001, UNAIDS co-sponsored a regional workshop on the MTCT to help establish regional focal points to assist in the implementation of MTCT programmes.

The approach involves three integrated strategies to reduce paediatric AIDS: a) Primary HIV Prevention in young parents, b) prevention of unwanted pregnancy and c) the prevention of mother to child transmission (PMTCT).

[17] UNAIDS by its nature is a partnership model within the UN system and consists of a coalition of six agencies (WHO, UNICEF, UNDP, UNESCO, UNDCP, UNFPA) of the United Nations system and the World Bank. Its mission is to facilitate the mobilisation of all partners desiring to participate in the fight against AIDS.

Migration and Mobility

In 1994-1995 with the support of the World Bank and WHO, officials of national AIDS control programmes, NGOs and associations of people living with HIV and development partners met several times to begin an inter country response to common concerns related to migration and HIV/AIDS.

The first phase of the regional initiative was started with the following priorities; migration and HIV/AIDS, sex work and HIV/AIDS, support and assistance for people living with HIV/AIDS and community mobilisation. Using a multi-sectoral team of researchers, NGOs and local communities' action research helped community actors' design suitable interventions for HIV/AIDS prevention. The first phase of the programme included: Burkina Faso, Cote d'Ivoire, Mali, Niger and Senegal. The initiative has been extended to include Ghana, Togo, Benin, Nigeria and Cote d'Ivoire. Local teams of researchers were trained to conduct action research and define the local actions related to the problems and interventions within the context of risk. Often bus stops, markets and hotels are used as the prime area of interventions for the educational response. An analysis of first phase outcomes reveals a high level of integration within traditional patterns of behaviour along migration routes and signs that the programme can be sustained by the local actors (i.e. truck drivers, communities and associations).

The second phase**" West African Initiative"** along the Abidjan-Lagos migration corridor has the following objectives:

- To reduce the vulnerability and risk of STD/HIV/AIDS infection in the context of mobility within the corridor
- To reinforce sub regional co-operation against AIDS

Implementing partners include USAID, CARE international, CIDA and GTZ. The World Bank is providing finance. (more information on the project is available on www.onsida-aoc.org)

The "**Initiative of countries of the Lake Chad Basin"** is another cross border project initiated by UNAIDS. The overall objective is to reduce the vulnerability and risk of STI/HIV and AIDS infections in the context of mobility within countries of the lake Chad Basin. Implementation partners include USAID and their projects, CARE international and other NGOs. The financial contribution is coming from a consortium of oil exploration in Chad and Cameroon. The approach involved a multi-dimensional approach based on local initiative from NGO's, local communities and stakeholders in the definition of programme interventions to arrest the spread of HIV/AIDS.

Poverty, Debt Relief and HIV/AIDS

Another window of hope which has emerged from the poverty reduction process involving several countries that are highly indebted (HIPC) is the freeing up of resources from debt relief for HIV/AIDS programming. Several countries within West Africa are considered "Highly Indebted" and have been asked to join the HIPC initiative. As part of the process countries are asked to prepare Poverty Reduction Strategic Plans (PRSP) and incorporate HIV/AIDS as a cross cutting issue. Key elements identified as essential to the response include: a concerted effort to put in place HIV/AIDS on the agenda, a

massive mobilisation of resources, a multi-sectoral approach to combating HIV/AIDS and a scaling up of interventions based on available evidence. (See UNAIDS, "AIDS, Poverty Reduction and Debt for more information.) A list of countries involved in the initiative are contained in Annex 2. UNAIDS has also launched a special initiative to encourage countries to utilise resources freed up from debt reduction towards HIV/AIDS programming across the sectors.

Regional HIV/AIDS Surveillance

A WHO AFRO initiative is being developed to strengthen the regional surveillance systems within the African region. The core elements of a second generation HIV Surveillance will be implemented in African countries. WHO AFRO is preparing a report for the year 2000. The HIV Surveillance report for the WHO Africa Region will contain technical analysis of the HIV/AIDS and STI situation in the region, serve as a one source description of the epidemiological surveillance in a standardised format, help identify gaps in the information provided by existing systems and contribute to the updating and consolidation of the AFRO database on HIV/AIDS and STI Surveillance.

4.3 Regional Strategies and Programme Focus

Several development partner programmes are also working on a regional basis to help combat the pandemic. Table 15 highlights the main programme focus of the UN agencies in West Africa. Annex 4 outlines the main bilateral responses to the HIV/AIDS pandemic.

Table 15: Regional HIV/AIDS Strategies and Programme Focus For Multi Lateral Agencies

Agency	Regional Strategies and Programme focus
UNICEF Regional Office	UNICEF country representatives of West and Central Africa in November 1999 adopted a strategic framework geared towards a reorientation of present UNICEF programme. Priority areas include: ➢ Prevention of mother to child transmission (MTCT) in the form of a pre-natal care package, safe maternity and within the context of the Bamako initiative ➢ Young people reproductive health (see "Sante des Jeunes: Comment passer de la reflexion a l'action?) ➢ A decentralised response from districts: "risk mapping in some countries (i.e. Burkina Faso) to identify populations with high level risk ➢ Consideration of the gender implications of the pandemic and the sectors response to education and the protection of orphans UNICEF with its partners is in the process of developing a regional youth strategy to target between the ages of 10-16 years of age. The main thrust of the strategy is to establish preventive activities especially among high-risk groups (girls out of school). Strong emphasis is also placed on mobilising NGOs and using a Youth to youth approach.

Agency	Regional Strategies and Programme focus
UNAIDS	Key priority areas for the UNAIDS regional strategy include: ➢ Assisting Governments develop a strategic planning process and concretise plans by January 2002 ➢ Focus on Vulnerable populations: migrants, refugees, young people and sex workers ➢ Support to people living with HIV/AIDS ➢ Prevention of Mother to Child Transmission ➢ Advocacy, information and communication through electronic and technical resource networks
WHO	WHO is focussed on a regional strategy to combat the spread of STDs due to their strong link in the prevention and control of HIV/AIDS. Four strategic components of WHO's work are: ➢ Health sector reform in order to strengthen AIDS control ➢ Strengthen prevention mechanisms (safe blood transfusion, vulnerable populations, screening and immunisation) ➢ Health care activities (mother to child transmission, health care to patients) ➢ Continued monitoring and follow-up of activities (problem of data collection and management of the epidemic) The WHO regional strategy for the control of sexually transmitted diseases (STDs) is aimed at strengthening and introducing national STD control programmes as a necessary component of HIV/AIDS prevention programmes. Priority interventions include: advocacy, the prevention of STDs/AIDS, management of STD cases and epidemiological surveillance, targeted interventions and the promotion of research. A regional consultative groups comprising STD/ADIS experts (STD/AIDS Task force) meets every year to evaluate progress and make recommendation for strengthening programmes at regional and country levels.
UNFPA	UNFPA focus is on young people and adolescents. The agency is involved in the development development of appropriate tools giving priority to interventions at regional, national and district levels. The programme focuses for 2001 to 2005 will relation to HIV prevention as part of adolescent reproductive health, Condom programming and commodity security, Prevention of MTCT, increasing male involvement in the prevention of HIV, Prevention in emergency and conflict situations and capacity building. UNFPAs focus is also on the reinforcement of data collection and analysis of epidemiological and behavioural data. The agency set up three technical teams based in Dakar (West Africa), Addis Ababa (East Africa) and Harare (Southern Africa) comprised of experts and resource people intervening and providing assistance at the demand of countries. Annual meetings of the UNFPA representative and technical support teams plan out strategies on a yearly basis.
UNDP	Has developed a strategic framework (1997-2000) for integrating HIV/AIDS within a development context. The key objectives were to minimise the impact of development on the spread of HIV and minimise the impact of HIV/AIDS on development. Focus areas include: communication of HIV and development, policy dialogue and analysis within the public sector, strengthened multi-sectoral programming, training of trainers, networking for PLWHA, private for profit programming for HIV/AIDS and strengthen local initiatives for HIV/AIDS prevention with civil society.
World Bank	Multi-country AIDS programme: US $ 500 million dollars in soft loans for Multi Country HIV/AIDS Programme for Africa (MAP). It is to spent by countries having a national, multi-sectoral and decentralised strategic plan. Nigeria and Burkina Faso have both received approach for two interest free credits to fight

Agency	Regional Strategies and Programme focus
	HIV/AIDS. Both countries have developed strategic approaches for HIV/AIDS and have established high-level HIV/AIDS coordinating bodies. (See www.worldbank.org/aids for more information)
WAEMU (West African Economic and Monetary Union)	WAEMU is a sub regional organisation comprising of 8 countries (Benin, Burkina Faso, Cote D'Ivoire, Guinea Bissau, Mali, Niger, Senegal and Togo). These countries mobilise resources to initiate joint programming in areas of epidemics and essential medicines. A co-operation agreement has been prepared with the WHO in order to provide a framework for the control of HIV/AIDS. The WAEMU objectives are to: ensure co-ordination of the response to the HIV/AIDS epidemic and socio-economic impact of HIV/AIDS.
ECOWAS (WAHO)	West African Health Organisation (WAHO) in the process of developing a HIV/AIDS Strategy for the region. The strategy will have a strong focus on AIDS care and support and put in place a plan of action for HIV/AIDS. To date: WHO, UNAIDS, UNICEF and UNFPA have endorsed the plan.
ADB (African Development Bank)	ADB has intensified efforts in the area of HIV/AIDS at policy and operational levels. ADB has developed HIV/AIDS strategies with partners and regional member countries (RMCs) in April 2000. It has also increases cumulative lending to combat HIV/AIDS in the health sector in 19 countries.

(Based on UNAIDS, A Synthesis Report: Regional Co-ordination Meeting, 10 May 2000, Burkina Faso and the United Nations Consolidated Interagency Appeal, 2001)

UNAIDS is planning to facilitate the integration of plans in order to develop a regional UN Strategy to combat HIV/AIDS in West Africa.

A special UN initiative called the "**Consolidated Interagency Appeal for West Africa**" is targeting countries, which are considered emergency and conflict areas within the sub region such as Liberia, Sierra Leone, Guinea and Cote D'ivoire. All UN agencies including UNICEF, UNFPA, WHO, FAO and UNAIDS ICTWCA are involved in this initiative, which focuses on HIV/AIDS programming in the following areas:

- Prevention of HIV/AIDS among children
- Care of Orphans
- Prevention of MTCT
- Promotion of behavioural change
- Empowering women
- Reinforcing institutional capacity
- Reinforcing capacities of actors involved in situational analysis, advocacy and evaluation

5.0 The Government Responses to HIV/AIDS across ECOWAS Countries

"The challenge for the leaders in Africa and their partners in development is to adapt and massively expand successful approaches that make it harder for the virus to spread, and that make it easier for those affected to live full and rewarding lives."
(UNAIDS Epidemic Update, 1999)

The following section will review some of the responses made by ECOWAS countries in their attempt to moderate the impact of HIV/AIDS epidemic. The first section will focus on the major factors, which support and impede national responses to the HIV/AIDS epidemic. The second section highlights the response across West African countries—the national plans, budgets and levels of response. The final section will review the experience of one West African Country, which reacted quickly to the HIV/AIDS epidemic and is showing signs of progress.

The UNAIDS (2000) Report on the Global HIV/AIDS Epidemic identifies eight common features for effective national responses. Table 16 summarises these features.

Table 16: Comparing major factors which support and factors, which impede effective national responses.

Major features common to effective national responses (UNAIDSa, June 2000)	Major factors which impede national responses (Wijerama, 1993)
1. Political will and leadership 2. Societal openness and determination to fight against stigma 3. A strategic response 4. Multi-sectoral and multi-level action 5. Community based responses 6. Social policy reform to reduce vulnerability 7. Long term and sustained response 8. Learning from experience 9. Adequate resources	1. Literacy rates and communication channels 2. Access to health care 3. Economic situation 4. Stigmatisation and discrimination 5. Sexual behaviour and attitudes 6. Religious concepts 7. Topography and geographic Location

These nine common features of the AIDS response in Sub-Saharan Africa suggest that the initial steps in any effective campaign require the **highest political will and leadership.** The African Forum for Development emphasised that different levels of leadership were required to control the spread and impact of the HIV/AIDS epidemic.

Wijermars (1993) in her analysis of HIV/AIDS across some West African Countries identifies several factors, which impede HIV/AIDS emphasising the need for literacy and communication channels. These conclusions have strong implications in West Africa where the rates of HIV/AIDS are increasing in an environment of strained socio-economic resources. High rates of illiteracy, low levels of health care and poor macro economic environment characterise many of the countries in the sub region.

Sexual behaviour has also been characterised by cultural and traditional practices, which enhance the spread of HIV/AIDS. The practice of polygamy, female genital mutilation, early marriage, fostering and other traditional arrangements, place women under the authority of the male household increasing their level of vulnerability to HIV/AIDS. The recent migration study by World Bank/UNAIDS (2000) reveals that women at tertiary level are vulnerable to HIV/AIDS due to the economic hardship they face in supporting themselves through University.

5.1 Situational Analysis across the West Africa

The following section reviews the current status of countries within ECOWAS in relation to their efforts to respond to HIV/AIDS. According to the Inter-country Team for West and Central Africa 11 out of 15 countries in Sub-Saharan Africa have developed HIV/AIDS national strategic plans. Table 17 provides a brief overview of the current state of the plans at National and the District levels across West Africa.

Table 17: West African Country Assessment according to HIV/AIDS policy/ programme status

Country in order of HIV/AIDS prevalence	Existence of National HIV/AIDS policy	Existence of HIV/AIDS policy in any sector	Existence of High level structure to support national response	National Strategic Plan on HIV/AIDS	Existence of budget for implementation of the plan
Cote d'Ivoire	Yes	No	Yes	Yes	Yes
Burkina Faso	Yes	Yes	No	Yes	Yes
Togo	Yes	No	Yes	Yes	N/A
Nigeria	Yes	Two sectors[18]	Yes	Yes	Yes
Ghana	Yes	Most sectors	Yes	Yes	Yes
Sierra Leone	No	No	Yes	No	N/A
Liberia	No	No	Yes	Yes	No
Guinea Bissau	No	No	No	No	No
Benin	Yes	No	Yes	Yes	N/A
Mali	Yes	No	Yes	Yes	No
Gambia	Yes	Four sectors[19]	Yes	No	Yes
Senegal	Yes	All sectors	Yes	Yes	Yes
Guinea	Yes	No	No	Yes	Yes
Niger	Yes	No	Yes	No	No
Cape Verde	Yes	Three sectors	Yes	Yes	No
Total number of countries with measures in place	12	6	12	11	7

(Based on UNAIDS Inter-country team for West and Central Africa Reports, 2001)

Most of the countries within West Africa have the necessary structures and policies required to ensure that the HIV/AIDS epidemic is abated. Twelve out of fifteen ECOWAS countries have national HIV/AIDS policies in place. Six countries have a HIV/AIDS policy within specific sectors such as health, education and/or the military. Twelve countries have put in place high-level structures to support the national response such as an inter-ministerial committees or national commissions. Eleven of

[18] The health and military sector have both formulated policies.
[19] Education, Health, Sports and youth all have AIDS policies.

the fifteen countries have national strategic plans but only seven countries have budgets to support these plans.

There are only a few countries, which do not have high-level structures in place to support the national response (i.e. Burkina Faso, Guinea and Guinea Bissau). Senegal, Nigeria and Ghana appear to be leading the national response to HIV/AIDS since they have **all** the necessary structures, processes and plans in place to combat HIV/AIDS. According to the UNAIDS report all the sectors agencies and ministries in Senegal have developed AIDS policies. They also have a national strategic plan and budget. Guinea-Bissau, Liberia, Sierra Leone and Niger have few if any regulatory and policy level frameworks for addressing the AIDS epidemic.

BOX 9: Supporting the Strategic Planning Process across West Africa

For more than a decade the spread of HIV/AIDS has been marked by the emergence of several planning processes initiated by institutions across the region. The Strategic planning process introduced by UNAIDS have revealed a level of efficiency in mobilising human and financial resources not to mention the mobilisation of various national actors.

UNAIDS in collaboration with its cosponsors, have developed four modular guides to be used in national HIV Epidemic control programmes for conducting strategic planning processes. These include the following modules for the strategic planning process:

- situational analysis,
- response analysis,
- strategic plan formulation,
- Resource mobilization and implementation planning.

To date several countries are involved in the strategic planning process. To meet the demand for technical assistance at the regional level UNAIDS has also developed a strategic planning technical resource network. The map below outlines the stage at which the country has reached with regards to the strategic planning process. The network contains 81 persons well versed in the strategic planning. To date seven missions were supported in the following countries: Cameroon, Togo, Guinea Conakry, Burkina Faso, Equatorial Guinea, Mali and Cape Verde, Niger. A guide for strategic planning has also been developed for technical resource persons within the region. The objective of the process is to assist Governments in West Africa develop strategic plans by the end of 2001 in order that they can better coordinate activities and mobilise resources for arresting the spread and impact of HIV/AIDS. The process helps Governments: assess their situation, develop possible responses and identify difficulties of response and priorities for mobilising funds for responding.

5.2 Government Responses: lessons learned

Lessons from other parts of Africa suggest the need for a quick response to the HIV/AIDS pandemic particularly when developing strong policy and strategic plans for combating HIV/AIDS. Table 18 summarises the characteristics of phases, which countries often experience if they do not respond quickly.

Table 18: Characteristics of the Slow National Response to HIV/AIDS

Characteristics of the transition
Denial phase ➢ General sense that HIV/AIDS was not a problem ➢ Perceived as mainly infecting "western gay men"
Waking up phase ➢ More realistic appraisal of HIV/AIDS as a potential harmful issue ➢ Widespread belief it was not any more serious than other diseases
Crisis phase ➢ Marked by significant change policy environment ➢ Governments begin to release surveillance data and host conferences on AIDS ➢ Government declares AIDS as a national crisis
Consolidation and action phase ➢ Rising levels of commitment through out the country and within NGO sector ➢ National Development Plans begin to address the impact of HIV/AIDS and call on all stakeholders to play a greater role in HIV prevention.

(Based on USAID, 1996)

West African Governments should learn from these lessons and attempt to move quickly towards assessing the socio-economic impact of HIV/AIDS, taking proactive steps towards prevention rather than waiting for the epidemic to reach a level of "national crisis".

5.3 Senegal's case: an early prevention response.

Senegal is a model country in terms of its response to the HIV/AIDS and stands today as one of the countries with the lowest infection rate in Sub Saharan Africa. The first reports of AIDS in Senegal were in 1986 when six cases were identified. The response was immediate with the government setting up a national AIDS programme. By 1987 a system to screen blood for transfusion was set up in all ten regions of the country. Senegalese researchers collaborated to establish research projects and data was used to generate political support for prevention campaigns.

The Senegalese government placed a clear message of support to confront the epidemic while countries within the region ignored the threat. Senegal was a key mover behind the AIDS declaration made by Heads of State at the OAU conference in June 1992. Senegal has also invested considerable resource for AIDS prevention between 1992 to 1996 it invested close to US $20 million.

The Government of Senegal aims to increase the share of health expenditures to 9% of current outlays, compared to about 7% at present. Political support for the HIV response has been remarkably consistent over time. Information campaigns for members of parliament were launched and other influential groups have been targeted for training and information on HIV related issues.

The government also supported a national survey of Moslem and Christian leaders to better understand the needs of their religious constituency. Educational materials were designed to meet their various information needs. Providing testimonials from people living with HIV/AIDS had a positive impact. In March 1995 the religious leaders gathered in a conference on AIDS and put their full support behind the campaign. Policy makers also supported community based leadership, NGOs and community organisations in their fight against AIDS. Policy makers targeted young people with information and by 1992 sex education was introduced in both primary and secondary school curriculum. Sex workers were required to have health checks as part of the registration process and STDs were treated so that the spread of the HIV infection could be monitored. Senegal was one of the first countries to establish a national STD control programme and one of the first to integrate STD control into the primary health care services.

The impact of the Senegalese approach has been dramatic. Knowledge of HIV among the general and specific populations has increased (99% of sex workers know about AIDS). Sexual activity and practices have also changed. More women are choosing to remain virgins for longer. Condom use has increased from less than one percent before the campaign to a dramatic increase to more than two thirds of women who have casual sex within the last 12 months. (UNAIDS, 1999a)

Suggested Responses, strategies and interventions

Several multilateral and bilateral agencies have suggested responses to the AIDS/HIV epidemic confronting African countries. The World Bank (1997) in "Confronting Aids: Public Priorities in a Global Epidemic" identifies a critical role for local and international NGOs in the fight against AIDS. These agencies act, as key agents in bringing preventive care to people the Government cannot reach. The report provides evidence that if programmes are introduced in areas where the epidemic is still nascent, ***"an early active government response encouraging safer behaviour among those most likely to contract and spread the virus, has potential to avert untold suffering and save millions of lives."*** It further stressed that even where the virus has spread widely among the general population, prevention among the people most likely to contract and spread the virus (i.e. sex workers, transport drivers), is **the most cost effective way** to reduce infection rates. Table 19 outlines the main factors, which governments should consider in developing strategies to prevent the spread of HIV/AIDS.

Table 19: Government Strategies to prevent HIV/AIDS

Influence individual choices	- provide information - Reduce costs of condoms - Reduce costs of sterile injection equipment - Raise cost of commercial sex and drug use - Raise girls' self esteem
Ease social constraints to safe behaviour	- Alter social norms - Raise the status of women - Reduce poverty
Set government priorities for preventing HIV	- Help poor to avoid HIV - Avert secondary infections - Augment private prevention efforts

(Based on World Bank, 1997)

Policy performance should be focussed on three main areas: expanding information, ensuring the prevention among the most likely groups to contract and spread HIV (i.e. sex workers etc) and making sure that the poor have access to a means of protection. Donors and other international partners should focus on countries in their nascent stages of the epidemic and finance public goods, which countries cannot afford to support collectively.

6.0 Local Responses to HIV/AIDS

"In an AIDS competent sub district, village or community, people should have access to information; people must be able to analyse their risk and vulnerability situations and determine their appropriate actions for prevention; and people living with HIV/AIDS should have access to quality care (at health centres and/or at home)" Communities often have the capacity to help each other to deal with problems; if community capacities are properly tapped, it can lead to effective and sustained community responses to HIV/AIDS.." (Inter country workshop on HIV/AIDS and Reforms for Health, April 1999, Gaoua District conclusions)

A local response to HIV/AIDS focuses on empowering communities and local governments to organise multi-sectoral responses, and development policies to tackle the impact of HIV/AIDS.

6.1 Community and NGO Responses to HIV/AIDS

Government's and multi-lateral agencies are paying more attention to "bottom up" approaches to combat the spread and improve the services to victims affected by HIV/AIDS. Community based or homegrown responses are essential for conveying appropriate messages to the public. The following section outlines some of the essential elements of these responses, which have emerged in West Africa.

Table 20: Experience of Community and NGO responses in West Africa

Country	Experience in the NGO sector
Cote d'Ivoire	Three HIV positive people launched Lumiere Action in 1994 in an effort to care for AIDS orphans and support their families. In 1997 the organisation had 25 children today it has several hundred. At the end of 1999 AIDS orphaned more than 420,000 children. Many foster families are overcrowded and children eat only one meal a day. Lumiere Action tries as much as possible to place children with their relatives. The organisations attempts to make the transition of fostering easier on the child through counselling and support to needy families who find it difficult to meet all the needs of their children.
Nigeria	Life Link Organisation (LLO) is an NGO founded in Nigeria in 1994 to prevent STI's among prisoners, prison staff, their wives and youth. Life link has reached more than 8,200 people in five states of Nigeria with its HIV/AIDS education programmes. They are one of the only groups focussed on prison communities. Prison populations are vulnerable groups due to high rates of homosexual practices (Study by Lagos Prison Officers Wives Association). Prisons have know begun programmes to ensure clean shaving instruments, needles and syringes are provided at medical units in order to curb the spread of the infection. The prisons now carry prevention programmes and peer health educators have been trained to form anti AIDS clubs.
Senegal	NGO's and grassroots organisations in Senegal are mobilising and using traditional and more modern forms of media to get the messages of HIV/AIDS prevention to local communities. A lorry mounted studio/stage presents concerts, community plays and artistic events to reach a wider audience helping improve the knowledge of the rural and urban poor The studio stages are mounted at primary and secondary schools in Senegal and have had a large impact on the introduction of HIV/AIDS prevention topics within the school curriculum. Private and local newspapers have also been publicising

Country	Experience in the NGO sector
	local community campaigns and activities. ENDA a national NGO has been particularly active in mobilising and building the capacity of traditional and modern social networks to use media for HIV/AIDS prevention, care and management. The relationship between NGOs and Media has not been without difficulties. Sometimes the media tries to portray the sensational aspects of HIV/AIDS. The partnership should be based on information exchange and mutual understanding of interests and concerns in order to meet the needs of both groups and avoid superficial interpretations of the facts and figures.

(Based on Voices from Africa 10: NGO Responses to HIV/AIDS, UN Non Governmental Liaison Service, May 2001)

One of the best examples of a community-based response, which helped to mobilise the nation, was in Burkina Faso. The following section outlines the main elements of the community level response and lessons learned.

6.2 The Case of Gaoua Health District

The Gaoua health district provides coverage for the PONI province in southwest Burkina Faso. The province borders Ghana to the east and Cote d'Ivoire to the south. It is a rural district of about 200,000 inhabitants, the regional district health head quarters is located in Gaoua with 18,000 inhabitants. The people have a long history of migration to neighbouring countries with emigration rates as high as 7% of the active population.

The HIV/AIDS situation was characterised the following way:

- Rapid spread of HIV/AIDS epidemic studies reporting at least 6% among blood donors, 27% among patients in the regional hospital and between 4% to 15% among pregnant women (Report from the Meeting of Ministers of Health of the OAU on HIV/AIDS May, 2000).

The local authorities and health development partners in Gaoua district lobbied for assistance from the capital city in order to organise a " local response" to HIV/AIDS in the area. The rural radio stations launched a well-designed information campaign to inform the population about the HIV/AIDS pandemic and its impact (UNAIDS Best Practice Series). NGOs operating in the district also developed culturally well-adapted messages to de-stigmatise and launch prevention and control programmes. NGO's were also engaged in the social marketing of condoms. They shared educational materials with other partners in the public and voluntary sectors. Several of the local formal community organisations and associations mobilised women to break traditional socio-cultural patterns, which could change the conditions of women such as family planning, circumcision/female genital mutilation, and family rights education. Community-based organisations and youth groups carried out peer education activities.

The society was very traditional so there were many socio-cultural practices, which had to be considered. For instance young girls had to prove their fertility before marriage by becoming pregnant. The district started to development a community plan to mobilise all the stakeholders including the religious leaders, women's associations, and youth groups in order to engage everyone. Through the religious leaders the messages of HIV/AIDS began to be disseminated. The people living with HIV/AIDS were organised into an association. With the local response the Hospital began a counselling, and home visit programme where doctors began visiting the communities.

In early 1997, the GTZ in collaboration with UNAIDS and WHO, initiated a comprehensive situational analysis as part of a 'local response' initiative. This analysis revealed a number of institutions and organisations were identified as already active in the HIV/AIDS prevention and care[20]. Three key principles highlighted in the study from Gaoua district were:

- Building people's capacity to understand their own situation is critical to an effective local response
- Facilitating the communities understanding can take time
- Health professionals should be encouraged to adopt positive attitudes to learn and be aware of their biases.

Following the communities own initiatives an external facilitator was appointed to assist Gaoua District expand their local initiatives in 1999. A multi-sectoral technical team became the driving force in charge of implementing local responses with three thematic groups on prevention, care and counselling and socio-economic impact. Consensus building and a common vision were developed between all the actors involved in the Gaoua District. Strategic planning and resource mobilisation were also part of the process of building on the existing initiatives the district had undertaken (UNAIDS 2000) Best Practice Case Study Gaoua District Local Responses).

[20] The Ministry of Health, rural radio stations, several other ministries, NGOs, local formal community based organisations and dozens of town and village level associations and informal self-help groups were engaged in the campaign.

7.0 Key Conclusions and Considerations for the Future

"HIV/AIDS is not just one more problem among many. It is an emergency epidemic--a development crisis-- that is ravaging the region and undermining all social and economic development efforts. A radical response that mobilises all sectors, including education, is imperative. (World Bank, 2000c)"

This study has attempted to review the current status of HIV/AIDS in West Africa in terms of prevalence, impact and response to the epidemic. It is clear from the analysis that countries within West Africa will be affected by the growing HIV/AIDS epidemic and should put in place effective measures to abate the storm. Over the last 10 years six more countries have reached beyond the 5% level joining Côte d'Ivoire with the highest adult rate of HIV infection in West Africa.

In countries where poverty is high and low levels of education are widespread, HIV/AIDS threatens to further impoverish the household and create a negative impact on macroeconomic environment. The productive and reproductive practices in societies should be carefully reviewed when identifying a multi-agency and government approach to minimising the impact. Experience from southern Africa suggests that political will and awareness at the highest levels is the primary ingredient in order to strengthen the campaign against HIV/AIDS and to ensure its success. This political will involves at the very minimum government commitment to putting in place high level structures such as inter-ministerial committees to mainstream HIV/AIDS awareness and strategies within each sector. It also involves the identification of cost effective approaches, which have proven effective in other parts of Africa and most importantly, the creation of public awareness concerning the current levels and impact of HIV/AIDS within a given country.

7.1 The Way Forward: Recommendations for Countries in West Africa

When exploring the demographic and social impact of the epidemic in Africa, women and children are the worst affected. Unlike other regions of the world, AIDS in Sub-Saharan Africa is mainly transmitted through heterosexual relations. Young girls between the ages of 15 and 19 are most vulnerable and will continue to be the primary target of the HIV/AIDS pandemic unless serious moral, educational and economic measures are put in place to combat the problem.

Girls' education has become a major focus for reducing poverty and reveals significant importance in the fight against HIV/AIDS. Studies in other development sectors have proven that investment in girls' education alone is the single most effective and efficient strategy for short and long term gains in reducing poverty and breaking the intergenerational poverty cycle. Government need to define both the short-term measures for HIV/AIDS prevention and care at the same time they begin to invest in longer-term measures such as moral and basic education. Training girls to become responsible citizens, empowered to make their own decisions will have untold benefits for the next generation of children. Girls' education appears to be the most pressing need for African governments, and the lasting solution to break the intergenerational poverty cycle, and arrest the spread of HIV/AIDS in the long run.

Efforts to prevent the spread of AIDS will also require greater public awareness and strategic interventions targeting people most susceptible and most vulnerable. Primary emphasis should be placed on strategies to prevent mother to child transmission, reach out to vulnerable groups, particularly sex workers, poor migrants and socio-economic groups which are likely to spread the virus; these are also among the most cost effective responses.

Governments across West Africa must place higher priority on the likely impact of the AIDS epidemic-- mainstreaming it across all key development strategies, programmes and sectors. Failure to learn from countries in southern and eastern Africa will have devastating impact on the generations to come. Key to this process will be the role of information and data collection. Universities and research institutions across West Africa should be at the forefront of providing governments with up to date data on the situation. Coordination between and within UN agencies and bilateral agencies will continue to be essential in spear heading an effective response to the HIV/ AIDS pandemic and ensuring action is sustained.

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Annex 1: Variables influencing the spread of HIV/AIDS in Africa

Virology Parameters	➢ Infectivity and virulence of HIV-1 strains ➢ Level of Viremia (immunodefiency
Local Genital factors	➢ Presence of other sexually transmitted diseases ➢ Male circumcision ➢ Use of certain vaginal products
Sexual behaviour	➢ Rate of partner change ➢ Sexual mixing patterns ➢ Type of sexual intercourse ➢ Size of and rate of contact with core groups ➢ Level of condom use
Demographic Variables	➢ Proportion of sexually active age groups to other age groups ➢ Male to female ratio in the population
Economic/Political parameters	➢ Poverty ➢ War and Social conflicts ➢ Status of roads and mobility of population ➢ Performance of the health care system ➢ Response to the epidemic

(P. Piot, J. Goeman and M. Laga, 1994 in ECA, 1999)

Annex 2: Countries involved in the HIPC initiative

Country	Poverty Reduction Strategy Status	PRSP date started
Benin	➢ Poverty Reduction strategy is under the Health Sector Policy. AIDS is considered as a particular case for which Government will prepare a strategy. ➢ Budget allocation for funding reproductive health and HIV/AIDS prevention.	PRSP will be finalised by April 2001
Burkina Faso	➢ HIV/AIDS is considered a health priority combating STI's etc. ➢ Impact of HIV/AIDS on the Education Sector recognised ➢ Public expenditures to be targeted to the poor and vulnerable.	
Gambia	➢ HIV/ADIS is defined as one of the causes of poverty and discussed under the "Health Policy Targets"	PRSP began in October 2000
Ghana	➢ HIV/AIDS is considered within a multi-sectoral approach to combating poverty	June 2000 began
Guinea Bissau	➢ Strong agenda for combating HIV/ADS within the PRSP	Sept 2000 began
Guinea	➢ HIV/AIDS is presented as an inter-sectoral approach having key objective to strengthen the action for combat the non medical aspects of HIV/AIDS	PRSP began in October 2000
Mali	➢ HIV/AIDS is not included in the eight key areas of the PRSP. It is mentioned under Health sectoral strategies. Linked to the national strategic plan on health development.	PRSP is under revision
Niger	➢ HIV/AIDS is part of the Health Sector Strategy and is discussed in a separate section on HIV/AIDS. A medium term action plan is being developed.	Began in October 2000
Senegal	➢ It is under the Health policy and social action section. Government aims to increase overall share of health expenditures to 9%.	Began in May 2000

Annex 3: Potential Impacts of AIDS on the household

Potential Impacts of AIDS on Families	Impact of AIDS on Children	Community Stresses
Loss of members, grief Impoverishment Children in family composition and in adult and child roles Loss of labour Forced Migration Dissolution Stress Inability to parent and care for children Loss of income for medical care and education Demoralisation Long term pathologies (increased depressive behaviour in children) Number of multi-generational households lacking middle generation will increase	Loss of family and identity Depression Reduced well being Increased malnutrition, starvation Failure to immunise or provide health care Loss of health status Increased demands on labour Loss of schooling/educational opportunities Loss of inheritance Forced migration Homelessness, vagrancy, crime Increased street living Exposure to HIV infection	Reduced labour Increased Poverty Inability to maintain infrastructure Loss of skilled labour, including health workers and teachers Loss of agricultural inputs and labour Reduced access to health care Elevated morbidity and mortality Psychological stress and breakdown Inability to marshal resources for community wide funding schemes or insurance

Annex 4: Regional Bilateral Agency Programmes across West Africa.

Agency	Project Details
CCISD: Centre for International Co-operation and Health Development	The centre is especially recognised for its work in prevention of STDs and epidemiological surveillance. The main programmes in West Africa focus on: Vulnerable groups, migration and prostitution in the context of mobility. CCISD also focussed on long term and short-term management of information and documentation of best practices. They are also development of technical regional resources on strategic planning and prostitution/migration model. AIDS 2 project is a prevention project based on 7 countries. It uses a syndromic approach geared at care and treatment of STDs.[21] ➢ The project objectives are to reduce HIV and STD transmission in West Africa through the use of clinical and community based approaches. The project gives priority to vulnerable groups and high-risk environments of infection. ➢ ADIS 2 project is developing trans-border activities carried out between Ivory Coast, Mali and Burkina Faso ➢ The project puts in place mechanisms, which strengthen national strategies, and link up inter country actions NGO's and community associations working with the target groups.
IPPF (International Parenthood Planning Federation)	A collaborative project between IPPF and UNAIDS since 1998 with the objective of building the capacities of IPPF to incorporate STDs and HIV/AIDS in reproductive health programming. The programme has developed training modules and built capacity of 132 facilitators in IPPFs programme areas. It has also developed an interregional network of IPPF human and institutional resources.
CIDA	Regional Office for AIDS/HIV is based in Ghana and funded by the Canadian International Development agency. The office is focussed on strategies which combat the spread of the virus amongst high risk groups (sex workers etc)
GTZ	GTZ has had an interregional technical team working to integrate HIV/AIDS programming at the national level across West Africa.
French Co-operation	French Co-operation across West Africa includes the establishment of two research centres on AIDS control in Abidjan and Dakar; the voluntary HIV testing centre, information, migration and support to persons living with HIV/AIDS. There is a fund established to assist community-based initiatives in the area of HIV/AIDS and Development.
USAID	USAID has been increasing support to HIV/AIDS programming through its country missions and bilateral programmes in (Ghana, Senegal, Nigeria and Mali). It has also started a West African Regional Programme (WARP) with the objective of increasing the usage of reproductive health HI/AIDS and Child survival services and products. They also support that Family Health and AIDS prevention programme (see below).
Family Health International	Project started in 1995 and established in 4 countries in West Africa (Burkina Faso, Cameroon, Cote d'Ivoire and Togo). The project has four main objectives: to promote the greater use of condoms and other STD/HIV services among sexually active adults, to develop capacity to implement these programmes, to develop trans-border interventions (i.e. Wake up Africa Initiative).
AFRICASO Or ICASA	Is a network established in 1991 of made up of NGOs, community associations and groups of persons living with HIV/AIDS throughout the continent. The

[21] According to best practice, syndromic approaches are applicable in areas where there are no laboratories.

Agency	Project Details
(International Council of AIDS service organisations	networks' objectives are as follows: information sharing, building the capacity of community groups and advocacy.
CERPOD (Centre for Population Studies and Development Research)	CERPOD is based in Mali and is a team of professionals working in the fields of population and development activities such as: migration and urbanisation, health and society, population and environment, family and development. CERPOD also manages a data bank and disseminated research results.
PANA (Regional Press Agency)	➢ Involved in the training of journalists on the effects of HIV/AIDS on the sector ➢ Creation of HIV/AIDS section on the PANA web site ➢ Resource mobilisation for adapted response to the epidemic ➢ Production of newsletters collected by PANA in the countries of West and Central Africa
IOM International Organisation for Migration	➢ UNAIDS is currently collaborating on a strategy for complementing and exchanging technical assistance.
SWAA Society For Women Against AIDS in Africa	➢ Promotion of rights and impact of HIV/AIDS on women in Africa. Africa Office is in Dakar.

Annex 5: UNAIDS Inter Country Team for West and Central Africa

The UNAIDS inter-country team for West and Central Africa (ICT/WCA) was established in October, 1996 with the following mission:

- To strengthen inter-country dynamics by supporting existing networks and initiatives
- To stimulate the development of exchange and collaboration mechanisms
- To support different stakeholders by mobilising expertise from within the region and by using skills of the inter country team
- To contribute to resource mobilisation and financial support for new and priority activities

The main objectives of the team are to:
- Provide an effective support to reinforce efforts related to HIV/AIDS prevention, care and impact mitigation.
- To build regional and sub regional capacity through awareness-raising and policy strategy formulation and
- To co-ordinate the activities of the United Nations System at the regional level.

The main strategies include: creation of networks, documentation on best practices and joint training programmes, planning and evaluation and resource mobilisation and conceptualisation and implementation of joint HIV/AIDS control policies and protocols and directives.

The strategic priority areas for 2000-2001 include a focus on:
- National Strategic Planning and local community responses
- Vulnerable populations (migrants, refugees, displaced persons and youth and sex workers)
- People living with HIV/AIDS (PLWHA)
- Mother to Child transmission and care and support
- Advocacy and Information/ communication

This year the UNAIDS inter-country team has facilitated several project initiatives including:
- Migration and mobility:
- Support to the National Strategic Planning Processes
- (GRIA) Regional Interagency Task force for the Prevention of HIV mother to Child transmission in West and Central Africa (GRIA)
- Support to Associations of PLWHA

For more information contact: www.onsida-aoc.org

Annex 6: Key Recommendations from the African Development Forum, 2000

Sector	Recommendations
Health	➢ The health sector must play a leading role in the prevention especially in minimising the mother to child transmission.
Education	➢ "The **Education sector** is central to the HIV/AIDS response and sex education should be in every curriculum. Schools should be models of equitable gender relations… all school fees and other charges… must be abolished. Donors should provide special support to the education sector." ➢ Youth out of school including street children should be targeted ➢ Drug prevention and rehabilitation programmes for youth and those out of school should be implemented.
Social Welfare	➢ "The social welfare sector must provide assistance to those caring for people with AIDS and for their dependants. Assistance including counselling should be provided for orphans."
Finance	➢ "Ministries of Finance should ensure adequate resource provisioning for HIV/AIDS programming." ➢ Enable funds for HIV/AIDS programming to flow easily and efficiently.
Trade, industry and mining sectors	➢ Should take responsibility for minimising the transmission of HIV and for non-discriminatory employment practices. ➢ Business and Labour should be involved in developing and implementing national HIV/AIDS action plans. ➢ Local production of pertinent pharmaceuticals should be considered
Rural sector	➢ Agriculture, livestock and fishing sectors should help promote the education on HIV/AIDS prevention.
Military sector	➢ Army must provide support for soldiers living with HIV/AIDS ➢ "The military must take steps to eliminate the high levels of sexual violence against women and girls, particularly during conflicts, and ensure that those responsible are prosecuted and punished." Similar measures should be put in place for officials from the prison and police service.
Commercial sex workers	➢ Should be protected by the laws and provided with education and access to condoms and medical facilities
African Research Institutes	➢ Should become involved in research for improved treatments for HIV/AIDS and opportunistic infections and draw on the knowledge of traditional healers
Media	➢ Information and communication technology should be used to facilitate the global transmission of information
Artists and cultural leaders	➢ Influence the public attitudes and can serve as role models.

Summary of the recommendations for the sector based on " The Consensus document" African Development Forum, 2000.