

The Socioeconomic Impact of AIDS +

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ABSTRACT

This article examines the impact of the AIDS epidemic on different sectors in sub-Saharan Africa – health, welfare, education and training, employment and agriculture. It notes that AIDS will have a complex, multi-dimensional impact on these various sectors and, in addition to the human tragedy involved, will seriously affect socioeconomic development in the region. The article urges a concerted multi-sectoral response to the epidemic on the part of policy makers, development workers and planners to work at establishing policies and programmes that can slow HIV transmission rates and help build viable support structures for those affected.

Introduction

The HIV/AIDS epidemic has at first, perhaps inevitably, been perceived internationally as primarily a health problem. Those outside the health sector considered its relevance to them peripheral. However, as the magnitude of the problem has become clearer, so, too, has the recognition of how far-reaching and comprehensive will be its impact in the worst affected regions, currently sub-Saharan Africa and, in the future, large areas of south-east Asia.

AIDS is rapidly becoming a critical issue for development in Africa. AIDS will not wipe out entire populations, as some alarmists have suggested. To lead to population decline in a country with a 3% or more annual growth rate (as in Zimbabwe, Kenya and many other countries in the region) would take HIV seroprevalence of over 40% (WHO GPA CNPEVA, 1993). So high a level in the general population is very unlikely. Nonetheless, AIDS will slow population growth substantially, it may reduce life expectancy by around 14 years by the year 2010 (Chin, 1992), and it is likely to negate decades of achievement in reducing child mortality. Already a quarter to a third of all adults aged 15 to 49 in many cities in central and eastern Africa have HIV and will almost certainly die of AIDS. Rural

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infection rates are also growing steadily, and agricultural production is likely to decline as a result. Adult mortality in the worst affected countries is set to triple because of AIDS during the 1990s.

There are four fundamental reasons why AIDS is a critical development issue, with repercussions far beyond the health sector alone (Ainsworth, 1993). The first is the scale of the infection, as indicated above. Globally, the WHO estimates that over eight million adults in sub-Saharan Africa, and 14 million worldwide, have already been infected with HIV. By the end of the century this figure is projected to reach at least 40 million. Second, there is little hope of an early vaccine, let alone cure, while it appears that almost all those who acquire HIV will, eventually, progress to AIDS and die. Third is the age range of those infected. Peak infections occur in women in their teens and early twenties, and in men in their twenties and early thirties. Thus peak AIDS deaths occur in women in their twenties and in men in their thirties, among adults in their prime productive and reproductive years. They are the people on whom the young, the old and the disabled depend, and they form the backbone of a nation's economy. Fourth, HIV affects all income and social groups, and both urban and rural populations. Initially it predominates in the elite in many countries, but later it becomes more a disease of the poor who are least able to protect themselves from infection. A vicious cycle is established, whereby the poorest sectors of society, and the poorest nations, are the most vulnerable to the epidemic and therefore suffer the worst consequences (Panos, 1992). This further impedes their development and increases their vulnerability.

Sub-Saharan Africa alone was estimated to have over 70% of the global total of AIDS cases by mid-1993 (WHO, 1993). HIV transmission and AIDS are exacerbated by a high incidence of sexually transmitted diseases, poor health facilities, inadequate condom distribution, and multiple partner change and casual or commercial sex. The last is exacerbated by urbanisation, overcrowding, the disruption of stable family units and cultures, migrancy or uprooted labour, landlessness, the inferior position of women and other facets of inequality. In addition, high levels of militarisation and the displacement of populations are major contributing factors to STD and HIV transmission in many areas. In the words of Sanders and Sambo (1991) initiatives to cope with HIV and AIDS:

"... will be perilously limited if they fail to confront such fundamental structural issues as the migrant labour system, women's position in society and the current economic recession with its attendant structural adjustment programmes".

World Bank and IMF-led Structural Adjustment Programmes (SAPs) both undermine the capacity to respond to AIDS and increase the rising of HIV transmission. Who can worry about AIDS ten years hence when they cannot feed themselves today? Awareness campaigns for behaviour change many have little weight.

Likewise, how can AIDS be made a priority among planners, policy makers, service providers, and the private and public sectors in general when the immediate economic situation is so problematic? AIDS is termed a long-wave disaster, requiring immediate and long-term solutions; but the slowness with which its devastation takes place precludes the mounting of a rapid multisectoral response. How or why plan for orphans when there are people facing malnutrition? Why consider the impact of AIDS on the labour force when there is mounting unemployment? By the time AIDS deaths really mount up the tragedy is that infection levels are already high. The devastation of family and community life and a severe impact on labour will already be guaranteed. Will policy makers, development workers, and planners be forced into ever more hopeless remedial action, or can they seize the initiative and develop policies and programmes to slow HIV transmission rates and establish viable support structures in time to help communities and organisations cope? It depends on whether they can grasp the true seriousness of the epidemic's potential impact *before* that impact is widely felt, and on far-reaching revision of current socioeconomic policies.

The Impact of AIDS on Different Sectors

AIDS will have a multidimensional impact at both macro and micro level because of its profound effect on labour and on family caretakers and providers. The macro impact on population, national income, and various aspects of national development will be complex and will vary from country to country.

However, some areas of impact are relatively obvious and predictable: increased health costs and numbers of orphans, for example. Others are less direct and harder to predict with certainty because so many factors are involved: the impact on agricultural production or on trade for example. Studies are increasingly being undertaken by the World Bank, UN bodies such as UNICEF and WHO, development organisations and NGOs, as well as by governments, to try and monitor and predict these consequences and to promote effective planning to mitigate the impact of AIDS. The following sections look briefly at different sectors and some of the salient concerns arising within them.

Health

The most immediate impact of AIDS is on the health sector, in which direct (ie patient treatment) costs will escalate dramatically. These costs, let alone the indirect costs of health promotion expenditure and the loss of productive labour, taxes, etc) are difficult to measure with accuracy because of the enormous under-reporting of AIDS and the difficulty of quantifying different health costs, including public health programmes. For example, hospital beds incur overhead costs regardless of whether they are utilised by AIDS or other patients, or remain unfilled; user fees may reduce hospital admissions even in the context of AIDS. Many patients are treated until they die without an HIV test or an AIDS diagnosis being made.

Nonetheless, estimates of direct costs have been made. Ainsworth and Over (1992) cite estimates that the direct costs of AIDS patient treatment in Tanzania, in 1991, would have been 40% of the total public health budget, and in Rwanda, 65% of the public health budget, had all patients been treated. With respect to the private medical costs of AIDS, CIMAS, a medical aid society in Zimbabwe providing about 45% of all medical aid in the country, has calculated that the last 18 months of an AIDS patient's life cost an average of Z\$6,000 (US\$ 800) (Hore, 1993). Thirty three percent of this is general practitioners' fees, 20% hospitalisation, 16% pathology, 12.5% specialists' costs, 10% drugs and 8% other costs. However, expenditure between these items varies widely from patient to patient. Among medical aid patients the biggest savings could be made in reduced GP fees. Given that many recorded visits do not incur drug or other treatment costs, the implication is that many visits may involve counselling and reassurance which, perhaps, nurses could give.

An estimated half or more hospital beds are already occupied by AIDS patients in many countries, and health services are forced to explore how to maximise home and community care for patients with AIDS. There are many potential advantages to the community as well as to the AIDS patient in maximising home care (Jackson, 1993). However, at its worst, home care may equate to home neglect, with patients receiving inadequate diagnosis of new infections and conditions, very little medical and nursing care, little or no symptomatic relief of distressing symptoms, poor nutrition, long periods alone and, eventually, a miserable death. Family caregivers may be overwhelmed by the workload in nursing a dying patient. Good home care requires a substantial investment, and well-developed referral networks, with hospital back-up where appropriate. Basic welfare concerns predominated in the AIDS home care survey undertaken in 1992 in Zimbabwe (Jackson,

1992), and it was clear that effective coordination and cooperation between the health and social services, and with local community groups, is vital for the success of home care programmes.

Among government patients reduced hospitalisation would potentially make the largest saving to health sector expenditure, but would increase the burden of care on the family and community. It is essential that the medical costs of AIDS be contained, or they could readily consume the entire health budget in time. On the other hand, optimal care within the budgetary constraints must be achieved through far-sighted cost-saving measures, reduced wastage and inefficiency, and the development of appropriate new services and treatment protocols. The emphasis will increasingly be on palliative care rather than expensive treatments which will only prolong life to a limited extent; many serious ethical issues are likely to arise regarding the allocation of resources and service provision.

Welfare

The primary welfare needs that arise because of AIDS are:

- the psychosocial needs of people with an HIV diagnosis through to the needs of dying patients and bereaved family members, including orphans
- escalating material needs of individuals and families who have lost their economic security, both formal and informal employment and subsistence activities
- children orphaned by AIDS. Although extended families may absorb these children in the short-term, soon the number of orphans becomes prohibitive, and the quality of care they receive is likely to be increasingly inadequate. This has already been documented in Zimbabwe (Chinemana, 1992), and is well known in parts of Uganda where up to two in five children are orphans because of war and AIDS (UNICEF, 1991):

"It was agreed (by community development workers) that generally orphans are living an unhappy life ...neglected, suffer(ing) from a lack of care, ... not properly fed ...not provide(d with) school fees or uniforms so the orphans ... cannot go to school ...Continual hard work at home, plus beatings, etc, may turn the orphan into a juvenile delinquent ... or a street child"

(Chinemana, 1992).

WHO estimates there will be 10 million maternal orphans from AIDS by the year 2000, of whom 90% will be in sub-Saharan Africa (WHO/GPA, 1992).

- elderly people who have lost the middle generation on whom they expected to depend in their old age. They may now be expected to become carers of orphaned grandchildren while they have increasing difficulty meeting their own needs
- widows who may be disinherited and unable to provide for their children or themselves. Many are forced into commercial sex to survive, with the attendant likelihood of further HIV transmission.

Welfare is affected at every level, the most fundamental being the family or household unit. At this level costs include:

- lost income
- lost household labour and increased household tasks (eg nursing sick patients)
- health costs over an extended period, often including payments towards hospitalisation, drugs, special nutrition, traditional healers, extra needs for bleach, detergent, sheets etc, transport and, ultimately, funeral and related costs. In southern Zambia a basic coffin alone is reported to cost US\$66, with most families spending up to US\$200. Funeral costs may exceed medical expenses for the family (Ainsworth and Over, 1992). In one family there may be multiple deaths, each incurring these costs several times over
- lost benefits, eg loss of medical aid, loss of pension and other occupational benefits at a time when medical costs are highest, and
- costs of maintaining other relatives, eg orphans.

More and more families will face not just one, but multiple deaths, thereby stretching family cohesion and coping mechanisms to and beyond their limit. a well coordinated, comprehensive response is needed by the state, NGOs and community organisations to support families' survival strategies. In reality, however, government health and welfare services are being widely curtailed through SAPs, placing an even heavier burden on NGO and community activities to meet growing demands.

Education and Training

AIDS will have multiple effects on who gains access to education, the need for expanded education and training, and levels of education and training provision. For example, many children in households affected by AIDS will be withdrawn from school to care for sick parents, or because there is no money for school fees and uniforms. Later, when they are orphaned, it is even less likely they will be able

to complete their schooling. Girls, in particular, will be at high risk of HIV infection as they sell sex to pay for school fees or merely to survive.

At the same time, the increasing death toll among young and middle-aged adults will create an increasing labour shortage (Whiteside, 1993). This will be felt disproportionately among skilled, professional and managerial staff, not because these are the main people who die, but because their skills and expertise are already in short supply. The death of one senior manager, doctor or teacher may cause far more repercussions than the deaths of twenty unskilled labourers who are easily replaced, and whose education and training has not cost the country and their families thousands of dollars (although the hardships experienced by their families may be greater). Ever more apprentices and trainees will be needed, and those with basic experience are likely to be promoted to replace skilled labour that is lost. Experience, however, cannot be replaced. Already in Uganda it is recognised that, to ensure an adequate supply of skilled labour, several trainees must be recruited for every vacancy in industry.

The level of provision and quality of education and training may, conversely, deteriorate as many teachers and trainers themselves succumb to AIDS. This may exacerbate the teacher shortages that already bedevil many countries in the region.

Employment

The impact of AIDS on industry, mining, tertiary services and other areas of formal employment will be felt most acutely in situations of:

- a highly skilled or professional workforce
- migrant or uprooted labour, eg on mines or farms, in the defence forces, the transport industry, rural-urban migration, etc.

The impact will nonetheless be felt to some degree throughout the public and private employment sectors, with 15-30% or even more in high risk areas dying. As more employees die at all levels of employment they will be increasingly hard to replace. Their years of training, skills and experience will be lost. The result will tend to be decreased efficiency, widespread demoralisation and lower productivity (Whiteside, 1993). The risks of discrimination, stigma and isolation will grow. The curtailing of occupational benefits to employees with HIV will mean more people needing social welfare benefits from a diminishing resource pool in most of the region. As each breadwinner succumbs to AIDS the probability is that an entire nuclear family becomes destitute and dependent on the extended family which will be increasingly overstretched. In many cases all terminal employment benefits and other savings the family may have had are utilised in the vain struggle to find a cure.

Employers may increasingly seek to curb the impact of AIDS on productivity and the workplace by discriminatory measures such as pre-employment and pre-training screening. The aim will be to keep out people with HIV, or to avoid expenditure on them. However these measures themselves incur economic costs, apart from their obvious ethical implications. The screening is costly, good applicants may be deterred from applying to agencies known to conduct screening, and such policies on a wide scale would lead to the removal from employment of thousands of valuable personnel during the remaining healthy years of their lives. In addition, an atmosphere of fear would be generated that would drive HIV and AIDS further underground and lead to higher infection levels. Effective prevention demands that AIDS becomes an open concern.

The Informal Sector

A severe impact is likely to be felt in the informal sector. Family dependence on subsistence farming and informal sector activities will increase when breadwinners in the formal sector die. Preliminary results of an analysis of family coping with AIDS in Zimbabwe notes this outcome (Jackson and Civic, 1994), which has also been observed in Uganda and elsewhere. Yet, to succeed, informal sector activities rely on experience, learning by doing and informal arrangements: as AIDS impoverishes communities it will become more difficult for them to sustain such activities, let alone an escalation of activity.

Agriculture

The impact of AIDS on agricultural production is difficult to measure, and will vary in different situations. However case studies in Uganda and elsewhere (Barnett & Blaikie, 1992) have highlighted the following impact at the household level:

- reduced income from agricultural production and non-agricultural work
- diversion of productive labour time to caring for the sick in the family
- diversion of cash to medical expenses (palliative and searching for a cure)
- diversion of food reserves to funerals
- withdrawal of children from school, both to reduce costs and increase farm and household labour
- changed patterns of consumption and production in households caring for orphans
- a move to less labour-intensive crops as farmers die and less labour is available, and away from crops requiring heavy seasonal inputs
- less intensive land cultivation, a narrower range of cropping, and reduced areas under cultivation
- poorer household nutrition as subsistence activities are curtailed, and lower levels of cash cropping.

Multiplied over many households the result could be a serious decline in agricultural production for both consumption and sale. Given that the majority of the population in the region is rural, large numbers of families are likely to be adversely affected. Commercial farms are likely to be affected too by increased morbidity and mortality among farm labour, with the risk that many children may no longer be able to stay on the farms when their parents die. There could be pressure on commercial farms to mechanise, leading to the loss of jobs over time, although with various crops seasonal labour demand will remain high. Many farmers will attempt to reduce their liability for orphaned children or destitute elderly. As well as the impoverishment of the grassroots, the national economy will be adversely affected if agricultural exports decline, as seems inevitable.

Comment

A concerted multisectoral response to the AIDS epidemic is urgently needed in all affected countries both to slow the spread of the epidemic and to assist infected and affected individuals, families, communities and organisations. By analysing and understanding the impact of AIDS across different sectors, better planning, policy and programme development may take place to mitigate the worst effects. Those who consider that AIDS is low priority in development planning should reflect whether, if around one in five of the workforce were ill and dying today, they would feel the same. If so, they are at least consistent. If not, then they must face the fact that this scenario will confront most sectors in many countries in the region within a decade. Planning for this eventuality now, and also aggressively adopting effective prevention policies, will improve the capacity to cope and may avert the higher projections for infection levels. Both human misery and the threat to economic development will be reduced. The writing is on the wall. There is no excuse for anyone to turn round a few years down the road and say, "If only we had known".

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