

SENIOR EXPERTS CONFERENCE ON HIV/AIDS AND EDUCATION IN ECOWAS
COUNTRIES: Towards Regional Mobilisation
March 19 to 23, 2001
Elmina, Ghana

HIV/AIDS IN ECOWAS COUNTRIES: REGIONAL DISCUSSION
PAPER NO.1

HIV/AIDS ACROSS ECOWAS COUNTRIES: The Prevalence, Impact and
Response.

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¹ The author would like to thank Mrs. Vivian Sarpornaa Fiscian from the University of Cape Coast, and Professor. John Anarfi from the University of Ghana for reviewing this paper.

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1.0 Overview of HIV/AIDS in the ECOWAS

" 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 African countries. Surprisingly, little research has been carried out to analyse the impact across ECOWAS countries. This paper is an attempt to prepare governments within ECOWAS to recognise and consider the macro and micro impacts of the HIV/AIDS epidemic before reaching a pandemic stage now experienced in other parts of Africa. Governments in the West African region must brace themselves for the 'coming storm', which threatens to:

- Substantially reduce the 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

The list goes on. This paper provides an overview of some of the most pressing concerns which countries within ECOWAS and their partners will face within the next five to ten years while the rate of Adult HIV/AIDS infection reaching beyond the 5% critical level. Currently only four out of 15 ECOWAS countries fall within this category but 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 micro to macro level. Already trends across the ECOWAS suggest that countries with high rates of HIV/AIDS among sex workers are set to move from an epidemic level to a pandemic level if drastic measures are not put in place immediately.

This paper provides an overview of some of the strategies, which are currently proving most efficient and effective. The first section will provide a situational analysis of the problem within Africa and ECOWAS countries. 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 strategies and programmes, which are currently in place across the ECOWAS and the key recommendations from the African Development Forum 2000 in Addis Ababa, which focused on the problem of HIV/AIDS in Africa.

This study was based on a desk review of literature and data from four main sources: UNAIDS, the World Bank, CIDA and GTZ. The majority of data is based on the UNAIDS/ECA (2000) Country-by-Country Report prepared for the Africa Development Forum and the UNAIDS (2000) Epidemiological Country Fact Sheets.

Literature from Southern and Eastern Africa was used to compare and supplement the limited data available from ECOWAS countries. Statistical data contained in this review is based primarily on UNAIDS data. More recent data was available from a few ECOWAS countries but this author used one main source in order to maintain consistency in comparing figures across the region.

1.1 West Africa within the Sub-Saharan African Region

Little research has been conducted to date with specific focus on the AIDS epidemic across the ECOWAS. Despite the presence of several HIV/AIDS programmes which cut across West Africa, little research is available apart from surveys conducted by UNAIDS (i.e. Country by Country assessment) which provide some 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 often covering only a few countries within ECOWAS (see World Bank/UNAIDS, 2000).

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 ECOWAS countries compared to the global and Sub-Saharan African figures.

Table 1.0: Global, Sub-Saharan and ECOWAS HIV/AIDS Burden, December 1999.

Key Indicators	Global Indicators (UNAIDS, 1999) ²	Sub-Saharan Africa (UNAIDS, 1999)	ECOWAS ³ (UNAIDS, update 2000)
New HIV infections in 1999	5.6 million	3.8 million	N.A.
Number of People Living with HIV/AIDS (end of 1999)	33.6 million	23.3 million	4.6 million
Deaths due to AIDS in 1999	2.6 million	2.2 million ⁴	462,800
Cumulative number of deaths due to HIV/AIDS since the beginning of the epidemic	16.3 million	13.7 million	1,7 million ⁵
Adult Prevalence Rate (%) ⁶	1.1 %	8.0%	3.7%
Percentage of HIV positive adults who are women (%)	46%	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 ⁷	N.A	2,7 million

(Based on UNAIDS Update, 1999; N.A. means not available)

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

- UNAIDS (2000d) estimated that out of the 33.6 million infected by HIV/AIDS -- 70% are in Sub-Saharan Africa.

² Global and Sub-Saharan figures are based on UNAIDS update 1999 and ECOWAS country figures are based on UNAIDS 2000 Update using 1999 figures.

³ Data not available on Cape Verde

⁴ Data from the UIJAIDS country-by-country report 2000 based on 1999 figures.

⁵ Available for only Nigeria, Guinea Bissau and Liberia

⁶ The proportion of adults (15-49 years of age) living with HIV/AIDS in 1999 using 1998 population figures.

⁷ Report on the Global HIV/AIDS epidemic (LINAIDS, 2000b).

- Sub-Saharan Africa has the highest rate of infection amongst adults and children in the world. Out of the 5.6 million of newly infected cases, 3.8 million are 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 and more than 70% of the total infected by HIV/AIDS are in Sub-Saharan Africa. ECOWAS Countries contain 13.6% of the total of people living with HIV/AIDS globally.
- 84% of the people who have died from HIV/AIDS since the beginning of the epidemic are in Sub-Saharan Africa and over 10% of these are from ECOWAS countries.
- Life expectancy at birth in southern Africa, which rose from 44 years in the 1950s to 59 in the early 1990s, is 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 (1999) 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. Unlike other areas of the world where women are between 10 to 30 percent HIV positive, in Sub-Saharan Africa, out of the total HIV/AIDS population over 55% are female. The reasons for the high rate of female infection in Sub-Saharan are 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 the HIV in Africa is the impact it is having on the young productive age group not to mention the children they leave behind. Approximately half of the people with HIV are infected before 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 old 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 in identifying strategies and targeting interventions particularly those, which support girl child education in Africa.

1.2 Socio-Economic Factors and HIV/AIDS in ECOWAS Countries

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 1.2 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 1.2: Key Socio-Economic Data for ECOWAS countries and the prevalence of AIDS

ECOWAS Countries ⁸	Adult Rate of HIV infection (%)	GNP (Per capita US \$)	HDI ⁹ Rank	Literacy rate (%)	Female literacy rate (%)	Life expectancy at birth	Under five mortality rate (Rank)	Primary school enrolment (1999)
Ivory Coast	10.76	710	154	40	30	47	150	69
Burkina Faso	6.44	250	172	19	9	45	169	38
Togo	5.98	340	145	52	37	49	125	133
Nigeria	5.06	280	151	57	47	50	187	89
Ghana	3.60	390	129	65	54	60	107	76
Sierra Leone	2.99	160	174	31	18	38	316	50
Liberia	2.80	-	-	38	22	48	235	35
Guinea Bissau	2.50	230	169	55	43	45	220	64
Benin	2.45	380	157	37	26	53	167	72
Mali	2.03	260	165	31	23	54	239	34
Gambia	1.95	240	161	39	25	47	87	73
Senegal	1.77	520	155	33	23	64	124	69
Guinea	1.54	550	162	36	22	47	201	48
Niger	1.35	200	173	14	7	49	320	29
Cape Verde		1200	105	72	64	67	73	131

(Based on UNICEF, 1999, State of the World Children and UNAIDS, 2000a)

Table 1.2 reveals the low levels of literacy within ECOWAS countries. This is a factor when designing preventive programmes for populations. The challenge of

⁸ Countries are ranked in order of highest rates of infection among the adult population aged between 15 and 49

⁹ The Human Development Index (HDI) is a quality of life indicator and includes information on education, health and income.

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 Africa fall within the top 20 countries for the highest levels of infant mortality ranging between 64 to 161 for every 1000 live births. UNDP (2000) study on poverty and HIV/AIDS reveals that families under the poverty line are more vulnerable to HIV/AIDS and experience greater impact from HIV/AIDS.

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 AIDS and HIV. Qualitative research from West Africa reveals that girls from lower socio-economic categories are more vulnerable to HIV/AIDS (UNDP, 2000).

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 the ECOWAS

HIV 1 and HIV 2 are both prevalent within ECOWAS countries. The presence of HIV 2 is a unique characteristic of HIV/AIDS, epidemic within the sub-region. The highest prevalence of HIV 2 is found in Guinea Bissau, Cote d'Ivoire and Burkina Faso (Wijermans, 1993). "HIV2 has been found in some other countries but often in people who had connection with West Africa" (Wijermans, 1993). Studies show that HIV 2 is less transmissible and harder to contract than HIV1. (Wijermans, 1993) Another challenge facing countries across the ECOWAS sub-region, is the increasing destabilisation from civil strife and ethnic conflict. Sierra Leone, Liberia, and Côte d'Ivoire all face particularly acute cases of ethnic and civil strife. The major consequences of conflict are the increased vulnerability to the infection. In addition data is harder to collect which creates added difficulty in monitoring, tracking and implementing prevention programmes across the countries. Recent studies also suggest that the transmigration of refugees will also be a growing source of HIV/AIDS transmission (World Bank/UNAIDS, 2000).

Migration patterns and trends

The following section highlights some of the 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 some 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 some ECOWAS countries including: Burkina Faso, Cote d'Ivoire, Mali, Niger and Senegal. Table 1.3 presents some of the key findings.

Table 1.3: 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 ¹⁰
Short Duration Migration	<ul style="list-style-type: none"> ➤ Traders or "Banabanas" (often single 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. 	<ul style="list-style-type: none"> ➤ Dakar-Bamako express ➤ Mali ➤ Mali and Cote d'Ivoire ➤ Sahelian Road axes (Mainly Niger Burkina Faso and Mali heading towards Ghana, Togo and Benin) ➤ Niger, Cote d'Ivoire, and Mali ➤ Mali, Senegal and Cote d'Ivoire
Medium Duration migration (few weeks to months)	<ul style="list-style-type: none"> ➤ Male and female merchants ➤ Agricultural labourers involved in seasonal migration ➤ Commercial sex workers and students 	<ul style="list-style-type: none"> ➤ Senegal to Mali, Burkina Faso, Gambia and Guinea or Mauritania ➤ Workers from Mali and Burkina Faso move to Cote d'Ivoire sugar factories, etc.
Long Duration Migration (several years)	<ul style="list-style-type: none"> ➤ Agricultural activities ➤ Socio professional activities by migrants in the host country (the sale of fabrics in Mali by people from Niger) 	<ul style="list-style-type: none"> ➤ Senoufo in Cote d'Ivoire and the Mossi from Burkina Faso
Prostitution	<ul style="list-style-type: none"> ➤ "sex workers were found to travel a lot in order to attract new clients" ➤ Sex workers are found in Togo, Cote d'Ivoire and Senegalese sites but rarer in 	<ul style="list-style-type: none"> ➤ Action Aid reported commercial sex workers in Burkina Faso are mainly from Ghana and

¹⁰ 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 ¹⁰
	their own areas. ➤ Sex workers from Niger are also found along the Bamako and Abidjan Axis.	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 activity and partners since people are far from their homes and have different social, religious and moral codes to guide their behaviour.

Recent studies from the Ghana and other Sub-Saharan African Countries indicate that HIV/AIDS is having a significant impact at the 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.

"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 Cote 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'" (Cote d'Ivoire)

" As far as students are concerned, we elaborate strategies to take hold of rich men and womanisers. 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 of HIV/AIDS but were pressured to find ways to meet their basic needs such as food, clothing and books.

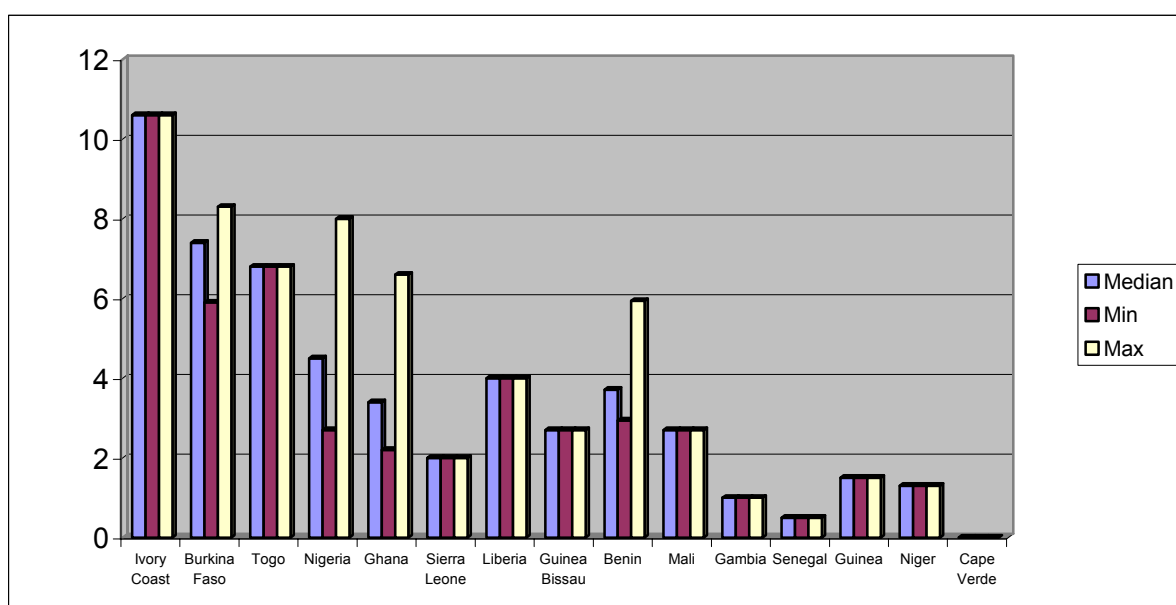
2.0 HIV/AIDS Prevalence across the ECOWAS Countries

The 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 the 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 progressively 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. Figure 2.0 provides data on the measured HIV prevalence across ECOWAS countries.

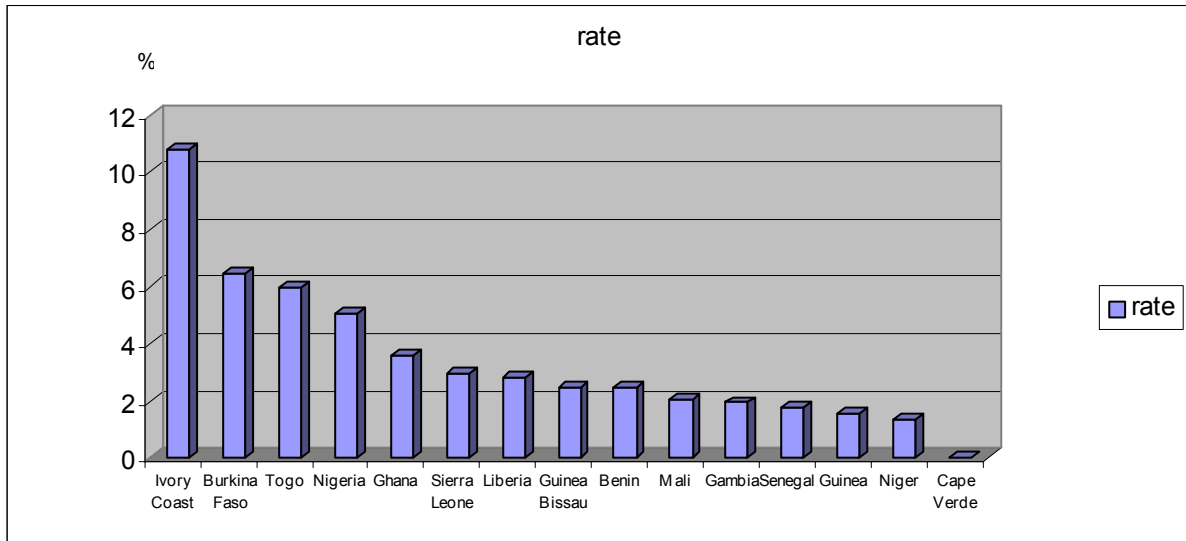
Figure 2.0: Measured HIV Prevalence in Antenatal Clinics in Major Urban Areas Across ECOWAS Countries
UNAIDS/ECA, 2000 Country by Country Report



	Ivory Coast	Burkina Faso	Togo	Nigeria	Ghana	Sierra Leone	Liberia	Guinea Bissau	Benin	Mali	Gambia	Senegal	Guinea	Niger	Cape Verde
Median	10,6	7,4	6,8	4,5	3,4	2	4	2,7	3,71	2,7	1	0,5	1,5	1,3	0
Min	10,6	5,9	6,8	2,7	2,2	2	4	2,7	2,94	2,7	1	0,5	1,5	1,3	0
Max	10,6	8,3	6,8	8	6,6	2	4	2,7	5,94	2,7	1	0,5	1,5	1,3	0

Cote d'Ivoire, Burkina Faso, Togo and Nigeria are among the countries with the highest prevalence rates (above 5% adult rate of infection). Figure 2.1 presents adult rates of infection across ECOWAS countries at the end of 1999.

Figure 2.1: Adult Rate of Infection across ECOWAS Countries, end of 1999



	Ivory Coast	Burkina Faso	Togo	Nigeria	Ghana	Sierra Leone	Liberia	Guinea Bissau	Benin	Mali	Gambia	Senegal	Guinea	Niger	Cape Verde
rate	10,76	6,44	5,98	5,06	3,6	2,99	2,8	2,5	2,45	2,03	1,95	1,77	1,54	1,35	0

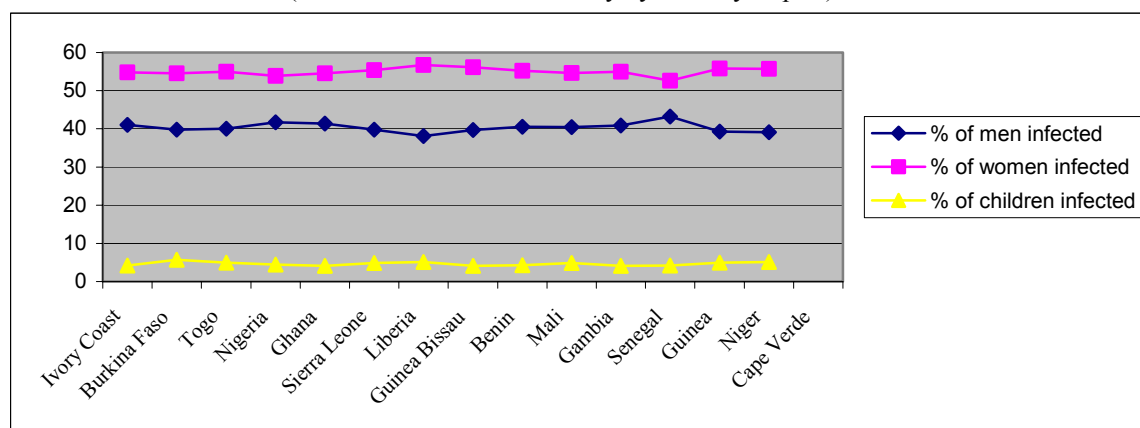
The four countries with the highest adult rates of HIV/AIDS infection among adults are Côte d'Ivoire with 10.76%, Burkina Faso with 6.44, Togo with 5.98% and Nigeria with 5.06%.¹¹ Data from some country strategies reveal even higher levels. For instance, the Ghana National Strategy document (2000) reveals that the adult rate of infection is as high as 4.6 percent. This researcher used one data source in order to remain consistent in comparing figures across ECOWAS.

2.2 Gender and Age Disaggregated Data

The following section explores gender-disaggregated data in order to see the particular 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. Figure 2.2 presents the main data for HIV rates among men, women and children across ECOWAS.

¹¹ Adult rates include all the people with HIV infection whether or not they have developed symptoms of AIDS at the end of 1999. Adults refer to people between the ages of 15 to 49 and are the most sexually active age group. (UNAIDS, 2000)

Figure 2.2: Gender and Age Disaggregated Data Based on Total HIV/AIDS Population
(UNAIDS/ECA 2000. Country by Country Report)



	Ivory Coast	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	53,85	54,55	55,38	56,76	56,15	55,22	54,64	55	52,63	55,77	55,74	
% of children infected	4,2	5,71	4,99	4,41	4,07	4,83	5,13	4,13	4,29	4,9	4,15	4,16	4,94	5,13	

The percentage of HIV infected persons who are children range between 4 to 6% of the total HIV/AIDS population. Mother to child transmission remains high in these countries (UNAIDS, 2000d).

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 2.1 presents the numbers of female sex workers between the 1980's and the 1990's infected by HIV/AIDS across West Africa.

Table 2.1: Rate of HIV/AIDS Infection among Sex Workers¹² 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
Burkina Faso	17 % (1986)	58 % (1994)	2
Togo	N/A	80% (1992)	3
Nigeria	2 % (1988)	30 % (1993/94)	4
Ghana	2 % (1988)	98% (1991) ¹³	5
Sierra Leone	N/A	27 % (1995)	6
Liberia	N/A	N/A	7
Guinea Bissau	N/A	N/A	8
Benin	5 % (1987)	54 % (1996)	9
Mali	39 % (1987)	74 % (1992)	10
Gambia	2 % (1988)	14% (1993)	11
Senegal	0 % (1986)	20% (1998)	12
Guinea	N/A	N/A	13

¹² 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. is

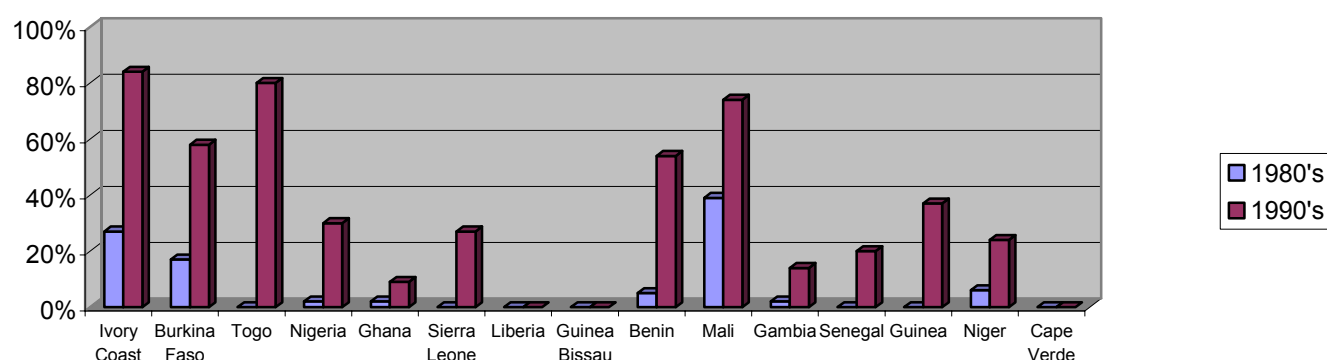
¹³ A more recent study in Ghana found that close to 98% of sex workers in Ghana are HIV positive.

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
Niger	6% (1987)	24% (1997)	14
Cape Verde	N/A	N/A	

(Based on UNAIDS Country by Country report, 2000)

HIV/AIDS infection among sex workers in Cote 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 even higher 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 2.3 presents the prevalence rate among sex workers in 1980s and 1990s across ECOWAS countries.

Figure 2.3: Sexworkers infected with HIV/AIDS in the 1980's and 1990's across ECOWAS countries.



	Ivory Coast	Burkina Faso	Togo	Nigeria	Ghana	Sierra Leone	Liberia	Guinea Bissau	Benin	Mali	Gambia	Senegal	Guinea	Niger	Cape Verde
1980's	27%	17%	0%	2%	2%	0%	0%	0%	5%	39%	2%	0%	0%	6%	0%
1990's	84%	58%	80%	30%	9%	27%	0%	0%	54%	74%	14%	20%	37%	24%	0%

Figure 2.3 presents the percentage of sex workers infected by HIV across ECOWAS countries. Correlation analysis of the sex worker rate of infection and 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).

2.4 The Spread and Transmission of HIV/AIDS

The HIV/AIDS prevalence across ECOWAS countries is 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 rate of HIV infection in: Botswana is 35.80 %, Swaziland 25.25%, Zimbabwe 25.06%; Zambia has 19% and Kenya with 13.5% (Kelly, 2001; UNAIDS 2000b). The incidence of HIV/AIDS is steadily increasing across the ECOWAS as depicted in Map 1 (Annex 1). Table 2.2 presents the number of ECOWAS countries, which have reached the categories of 5-10% infection rate of transmission over the last 15 years.

Table 2.2: Spread of HIV/AIDS infection among ECOWAS countries

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 Ca Verde	2 Burkina Faso Togo	1 Cote d'Ivoire
1999	11 (Same as above except Nigeria moved to next category).	3 Burkina Faso Togo Nigeria	1 Cote d'Ivoire

(Based on UNAIDS, 2000 update)

Reasons for the spread of HIV/AIDS across some ECOWAS Countries

A desk 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 ECOWAS countries (Wijermans, 1993). Table 2.3 presents some of the findings.

Table 2.3: Suggested reasons for transmission across some ECOWAS countries

Country	Suggested reasons
Benin	<ul style="list-style-type: none"> ➤ 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 aid sex to support the family.
Burkina Faso	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ In 1992, 75% of the registered AIDS cases were among people infected with HIV outside the country particularly women who were engaged in the sex trade (ie.Côte d'Ivoire)
Mali	<ul style="list-style-type: none"> ➤ 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 Wijermans, 1993 findings)

The high rates of migration on both 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.

3.0 Impact of HIV/AIDS across ECOWAS Countries

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 may also face 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 reports submitted to UNAIDS for the African Development Forum in December 2000.

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 3.1 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 ECOWAS and Sub-Saharan African countries 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 3.1: Framework for exploring impacts of HIV/AIDS epidemic

Type of Impact	Specific indicators to consider
Demographic Impact	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ % Change of GDP growth over time and as a result of HIV ➤ Demand and supply of various services are affected
Sectoral Impact: <ul style="list-style-type: none"> ➤ Education ➤ Agriculture ➤ Business/private sector ➤ Health 	<ul style="list-style-type: none"> ➤ 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) ➤ 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 ➤ 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 ➤ Share of hospital beds occupied by HIV positive patients ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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). Most 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 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.

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 3.1 presents a summary of information related to impact on macro and micro levels. Countries have been divided into 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 3.2: Macro and Micro impacts across ECOWAS countries

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)	<ul style="list-style-type: none"> ➤ Costs of financing the health sector in order to scale up AIDS programmes range from 1-3% of GDP (see annex 2) 	<ul style="list-style-type: none"> ➤ Household level impact and impact in the health sector
5-9 % of HIV/AIDS infection within the adult population ¹⁵ (Burkina Faso, Togo and Nigeria)	<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ➤ 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)	<ul style="list-style-type: none"> ➤ Macro Economic Impact estimate a loss of .8% GDP growth per capita as a result of AIDS (Bonnell, 2000) 	<ul style="list-style-type: none"> ➤ 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 the

¹⁴ Most ECOWAS countries fit into this category.

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

- 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 Impact at the household and community level

The following section explores the data available concerning impact across the ECOWAS and supplements this with studies from southern and eastern Africa. Table 3.3 reveals some of the impact trends at the household and community level based on UNAIDS Country by Country report (2000).

Table 3.3: Impact at household level across the ECOWAS

Country in order of HIV/AIDS prevalence	Impact at household level
Burkina Faso	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Illness and death lead to increased expenditure, reduced savings and shifts in productivity patterns.

(UNAIDS/ECA, 2000 Country by Country report)

Reports from Uganda suggest that the impact on the household and community is reflected in changes in the socio-cultural attitudes and patterns within society. The following case from Uganda highlights the impacts at this level.

Impact of HIV/AIDS in Gwanda, Uganda

In a heavily affected community such as Gwanda, the social impact is enormous. Gwanda is one of the first communities in Uganda to experience the HIV/AIDS pandemic. Since little was known about HIV/AIDS few people took any precautions and the community lost many young men, women and children. Almost every household was affected. The community had several graves of people who had died of AIDS, and most women and youth groups were simply focussed on providing assistance to widows and orphans- Despite the widespread trauma, many of the youth continued to have indiscriminate sex with widows or widowers of people who had died of AIDS. Interviews in the community revealed that many of these youth had a fatalistic attitude and believed that they would all eventually die of AIDS. The younger teenage girls in Gwanda had a different attitude and were frightened of contracting AIDS. Due to their poor social and economic status they were often forced into early marriage and premarital sex. Interviews in the community revealed that if they had financial support they would abstain from premarital sex and early marriage to older men. Some people in the community had changed their social and sexual behaviour to prevent contracting HIV/AIDS. Another problem was that most families were fostering orphans from deceased relatives and the only way to stay alive was to stop.

This case presents insight into the personal and communal trauma of HIV/AIDS caused by increased stress on the family and community level due to the increasing numbers of orphans, and the fatalistic behaviour among youth. The case of Gwanda community in Uganda and the research by World Bank /UNAIDS (2000) in selected West African countries highlight the vulnerability of women especially teenagers to HIV infection. USAID (1996) research on the socio-economic impact of AIDS in Kenya also suggests "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

FAO (1995) also reported on the social impacts of HIV/AIDS at the- household level stating that the epidemic in Uganda, Zambia and Tanzania had:

- 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
- Changes in the attitudes to indiscriminate sex

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

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 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.

Poverty and HIV/AIDS

UNDP's (2000) analysis of the poverty and HIV relationships suggest that the poor are more susceptible to the HIV/AIDS infection and there is an intergenerational impact on the poverty cycle 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--- most evidently in the a 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

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.

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.

3.4 Impact within the Education Sector across the ECOWAS Countries

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 3.5 summarises these factors:

Table 3.5: Measuring Impact in the Education Sector

Factor	Impact in the Education Sector
Demographic	Decline in size of school age population due to: <ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Fewer resources for schooling children ➤ Reduction in the size of the school age population
Supply side	<ul style="list-style-type: none"> ➤ Increased mortality particularly among teachers ➤ Increased absenteeism among teachers ➤ Increased unproductive work hours due to poor health
Potential clientele for education	<ul style="list-style-type: none"> ➤ Number of children being orphaned as a result of the epidemic ➤ Increasing number of orphans
Educational planning	<ul style="list-style-type: none"> ➤ 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. These mortality rates 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 3.6 presents the main results for countries where data was available.

Table 3.6: Impact on the Education Sector

Country in order	Impact on the Education Sector (based on the number of teachers
-------------------------	--

of HIV/AIDS prevalence	who may die from HIV/AIDS) (Based on UNAIDS/UNICEF modelling in 2000)
Côte d'Ivoire	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Out of 700,000 primary school children 7400 would have lost a teacher to AIDS in 1999 (% 1.06)
Togo	<ul style="list-style-type: none"> ➤ Out of a sample of 830,000 children, 7300 would have lost a teacher to AIDS. (% 0.88)
Nigeria	<ul style="list-style-type: none"> ➤ Out of 14.8 million primary school children 85000 would have lost a teacher to AIDS in 1999 (% 0.57)
Ghana	<ul style="list-style-type: none"> ➤ Gains made in enrolment will decline with the HIV/AIDS infection
Sierra Leone	<ul style="list-style-type: none"> ➤ 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. ➤ 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	<ul style="list-style-type: none"> ➤ Out of 750,000 primary school students, 1800 have lost a teacher to AIDS in 1999 (0.24%) .
Mali	<ul style="list-style-type: none"> ➤ Out of a total of 780,000 primary school students, 2000 have lost their teacher to AIDS in 1999 (0.26%) .
Senegal	<ul style="list-style-type: none"> ➤ Out of 900,000- primary school pupils at least 2000 are estimated to have lost a teacher to AIDS (0.22% in 1999) .
Gambia	<ul style="list-style-type: none"> ➤ Out of 140,000 primary school students, 353 have lost a teacher to AIDS in 1999 (0.25%) .
Guinea	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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)

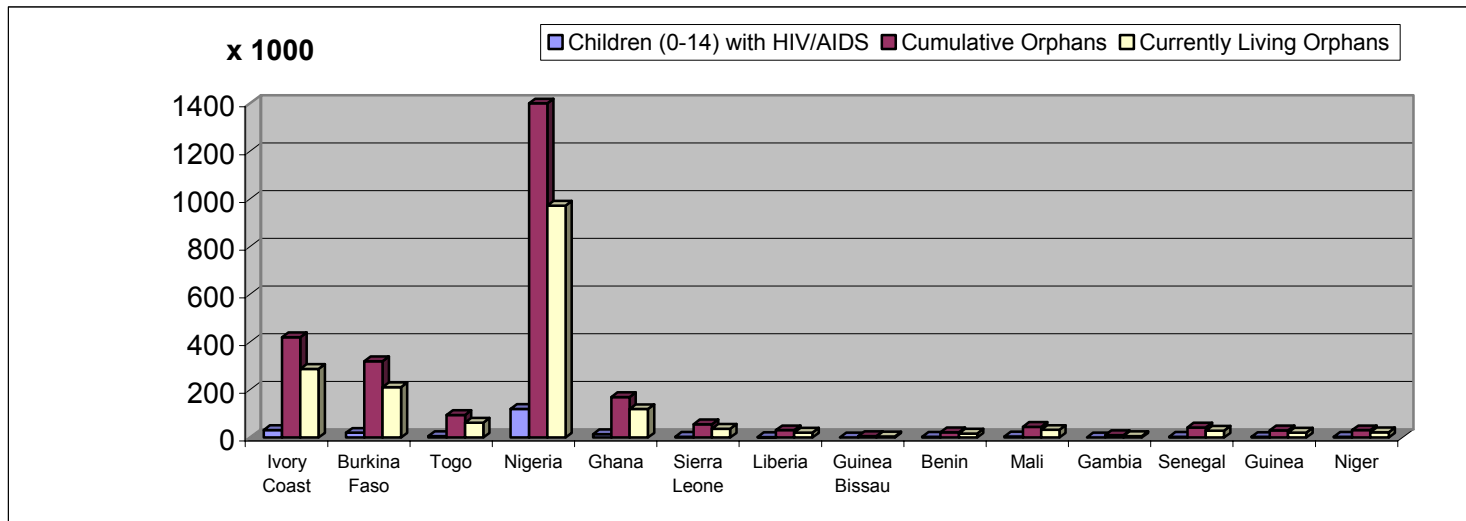
Table 3.6 reveals that only between 0.2% to 1.7% of primary school pupils have lost a teacher to AIDS based on UNICEFS modelling exercise. The impact is higher in countries with higher rates of infection.

Children infected with 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 moves beyond 5%. Data was not available on the number of children who have died from AIDS over the last few years in the ECOWAS. Figure 3.1 presents data on the cumulative number of orphans and the number of orphans currently living across the ECOWAS countries.

Figure 3.1 indicates that Nigeria has the-highest number of children currently living as 'AIDS orphans' followed by Côte d'Ivoire and Burkina Faso, Ghana and Togo.

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



x 1000	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	20	6,3	120	14	3,3	2	0,56	3	5	0,52	3,3	2,7	3,3
Cumulative Orphans	420	320	95	1400	170	56	31	6,1	22	45	9,6	42	30	31
Currently Living Orphans	287,269	211,503	63	971,472	119,411	36,456	20,337	4,194	16,741	32,171	6,076	29,023	21,037	21,741

3.5 Impact in the Health Sector across ECOWAS countries

This section presents the main impacts on the health sector. 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 3.7 summarises the main impacts of HIV/AIDS on the health sector.

Table 3.7: 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)
Cote d'Ivoire	<ul style="list-style-type: none"> ➤ 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. 	<ul style="list-style-type: none"> ➤ 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)
Burkina Faso	More than 50% of hospital beds are occupied by those with AIDS related illnesses	<ul style="list-style-type: none"> ➤ Annual costs of scaling up HIV/AIDS programmes is between US \$ 37 million and US \$ 57 million.
Togo	<ul style="list-style-type: none"> ➤ Increasing demand on the health sector due to HIV/AIDS 	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 1-2% of teaching hospital beds are occupied by AIDS patients 	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Ministry of Health estimates AIDS related bed occupancy at 50% in 2000 and over 90% in 2010. 	<ul style="list-style-type: none"> ➤ Large gap in funding is needed to scale up programmes (US \$ 55 million and US \$ 87 million)

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)
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	No information available	Large Gap in funding to meet the HIV/AIDS programming needs is 12 to 18 million U.S dollars. In 1995 a model 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

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 Cote d'Ivoire, Burkina Faso and Ghana 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 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 (Cote 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.

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

- Evidence in Cote 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.
- 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.

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.

CIDA (1999) report on the economic impact of HIV/AIDS indicates 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.

Companies in Botswana where infection rates have reached over 25% report that they hired additional health workers to serve as AIDS educators (Family Health International AIDSCAP project). These nurses train employees as peer educators provide information and support. They organise formal and informal peer education sessions for employees. Condoms are also readily available from vending machines next to the men and women's washrooms at a very nominal price. All new employees undergo HIV/AIDS training as part of the company orientation.

3.7 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. Table 3.4 presents some of the impacts reported in two ECOWAS countries.

Table 3.4: 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)
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)

Data from Tanzania, Uganda and Zambia, where the HIV/AIDS rate of infection is much higher, provides further understanding of the impact in the agriculture sector. 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 found that the impacts of HIV/AIDS were age and gender specific across all three countries. Considering that women carry the bulk of the farm workload in large parts of Africa, and are also the most at risk, the study found that the epidemic has significant implications for agricultural labour. Many households in Uganda are experiencing 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. 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.

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

4.0 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 of ECOWAS countries-the national plans, budgets and levels of response. The final section will review the experience of one East African Country which had a delayed reaction to the HIV/AIDS epidemic and the consequences of this response.

The UNAIDS (2000) Report on the Global HIV/AIDS Epidemic identifies eight common features for effective national responses. Table 4.1 summarises these features.

Table 4.1: 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)
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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**. This is confirmed by the recent African Forum for Development, which emphasised the different levels of leadership required to control the spread and impact of the HIV/AIDS epidemic. Wijermans (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 (see Table 1.2).

Sexual behaviour has also been characterised by cultural and traditional practices, which enhance the spread of HIV/AIDS. Practice of polygamy, female genital mutilation, early marriage, fostering and other traditional arrangements, which place women under the authority of the male household cause women to be in a particularly vulnerable position. 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.

4.1 Situational Analysis across the ECOWAS

The following section reviews the current status of countries within ECOWAS in relation to their efforts to respond to HIV/AIDS. According to the latest UNAIDS update more than 20 countries in Sub-Saharan Africa have developed HIV/AIDS national strategic plans and frameworks since 1997. Table 4.2 provides a brief overview of the current state of the plans at National and the District levels across the ECOWAS.

Table 4.2: ECOWAS Country Assessment according to HIV/AIDS policy and 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
Côte d'Ivoire	No	No	No	Yes	Yes
Burkina Faso	Yes	No	Yes	Yes	Yes
Togo	Yes	No	No	N/A	N/A
Nigeria	Yes	Two sectors ¹⁷	No	N/A	N/A
Ghana	Yes	Three Sectors ¹⁸	No	No	No
Sierra Leone	No	No	Yes	N/A	N/A
Liberia	Yes	Two sectors ¹⁹	No	Yes	No
Guinea Bissau	No	No	No	Yes	No
Benin	Yes	No	No	No	N/A
Mali	N/A	No	Yes	No	No
Gambia	Yes	Four sectors ²⁰	No	No	No
Senegal	Yes	one sector ²¹	No	Yes	Yes
Guinea	Yes	All sectors	Yes	Yes	Yes
Niger	N/A	No	No	No	No
Cape Verde	Yes	Three sectors	Yes	Yes	No
Total number of countries with measures in place	10	7	5	7	

(Based on the UNAIDS/ECA Country by Country Report, 2000)

Some of the countries with the highest rates of HIV/AIDS infection among adults do not have a strategic plan nor a high level structure to support the national response

¹⁷ The health and military sector have both formulated policies.

¹⁸ There are HIV/AIDS policies for the health sector, military and workplace.

¹⁹ Health and Military both have HIV/AIDS Policies.

²⁰ Education, Health, Sports and youth all have AIDS policies.

²¹ Health

(i.e. Cote d'Ivoire and Togo). Guinea appears to be leading the national response having put in place all the necessary macro level processes and programmes to tackle HIV/AIDS. According to the UNAIDS report all the sectors in Guinea have developed AIDS policies. They also have a national strategic plan and budget. Guinea-Bissau, and Niger have little if any regulatory and policy level frameworks for addressing the AIDS epidemic according to the UNAIDS (2000).

Apart from Burkina Faso, few countries within ECOWAS have put in place all the necessary structures and policies required to ensure that the HIV/AIDS epidemic is abated. Ten out of fifteen ECOWAS countries have a national HIV/AIDS policy in place. Seven countries have a HIV/AIDS policy within specific sectors such as health, education and/or the military. Five countries have put in place a high level structure to support the national response such as an inter-ministerial committee or commission. Seven of the fifteen ECOWAS countries have National strategic plans but only four of these have budgets to support their plans.

4.2 Government Responses in East Africa

Lessons from southern and eastern Africa can provide valuable insight into the problems which some countries face in developing strong policy and strategic plans for combating HIV/AIDS. Lessons from Kenya suggest that the government went through a four-phase process before reaching a level of awareness and intervention, which brought together all the stakeholders to combat HIV/AIDS. Table 4.3 summarises these phases:

Table 4.3: Characteristics of the Kenya's Four phase transition

Phases	Characteristics of the transition
1984 to 1987	Denial phase First case of AIDS identified in 1984 General sense that HIV/AIDS was not a problem Perceived as mainly infecting “western gay men”
1988 to 1991	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
1992-1995	Crisis phase Marked by significant change in Kenya's policy environment Government releases surveillance data and hosts first national conference on AIDS Ministry of Health declares that AIDS is a national crisis
1995 to date	Consolidation and action phase Rising levels of commitment through out the country and within Government and NGO institutions National Development plan 1994-1996 addresses the development impacts of HIV/AIDS calling for all stakeholders to play a greater role in HIV prevention.

(Based on USAID, 1996)

The case of Kenya suggests that a slow awareness and response by Government towards the HIV/AIDS epidemic can have devastating impact on the country. ECOWAS 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".

4.3 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 4.4 outlines the main factors, which governments should consider in developing strategies to prevent the spread of HIV/AIDS.

Table 4.4: Government Strategies to prevent HIV/AIDS

Influence individual choices	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Alter social norms - Raise the status of women - Reduce poverty
Set government priorities for preventing HIV	<ul style="list-style-type: none"> - 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 make sure that the poor have access to a means to protect themselves. The report also urges donors and other international partners to focus on countries in their nascent stages of the epidemic and finance public goods, which countries cannot afford to support collectively.

4.4 The African Development Forum, 2000 "Consensus"

The following section reviews the key conclusions from the African Development Forum (ADF) 2000 which focused on the HIV/AIDS pandemic. 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."

Multi sectoral leadership requires that every sector be involved in the planning of HIV/AIDS strategies. Table 4.5 outlines the main recommendations across the sectors.

Table 4.5: 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	<ul style="list-style-type: none"> ➤ "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 dependents. Assistance including counselling should be provided for orphans."
Finance	<ul style="list-style-type: none"> ➤ "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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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

Sector	Recommendations
	should be put in lace for officials from the prison and lice 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.

The ADF 2000 also presented a plan of action, which emphasised the initial steps for national government action:

- Each country should hold a representative national workshop by mid-February 2001 to consult on the plan of action and the approach to its implementation on a national level.
- All governments and civil society organizations should prepare reports for the Special Summit of the OAU on HIV/AIDS by mid-March.
- By the end of 2001, each country should ensure that they have a national AIDS Commission and a strategic plan backed by legislation, modalities and mechanisms for monitoring.

This conference on " HIV/AIDS and EDUCATION in ECOWAS COUNTRIES" is a further initiative towards this response.

5.0 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 paper has attempted to review the current status of ECOWAS countries in terms of prevalence, impact and response to the HIV/AIDS epidemic. It is clear from the analysis conducted that countries within ECOWAS 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 three more countries have reached beyond the 5% level joining Cote d'Ivoire with the highest adult rate of HIV infection in the ECOWAS.

In countries where poverty is high and low levels of education are widespread, HIV/AIDS threatens to further impoverish both the household and macroeconomic environment. The productive and reproductive practices in society 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.

Looking Forward: Recommendations for ECOWAS Countries

When exploring the demographic/ 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.

In the educational field, where girls' education has become a major focus of development partners, there are signs of hope. 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. What better way can we answer the request of girls who are forced to find ways to meet their basic needs at primary, secondary and university levels' than through a concerted campaign within the education sector. Let us define both the short-term measures but not forget that investment in moral education and basic education can train girls to become responsible citizens, empowered to make their own decisions and identify the options open to them not to mention the 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 to strengthen the fight against AIDS in the long term. Improving the situation for girls and women will require a gender equity approach, which involves men and women in the strategies for combating the HIV/AIDS pandemic.

ECOWAS governments should 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 ECOWAS should be at the forefront of providing governments with up to date data on the situation.

Finally, efforts to prevent the spread of AIDS will require greater public awareness and strategic interventions targeting people most susceptible and most vulnerable. Strategies to prevent mother to child transmission, free condoms to vulnerable groups, particularly the sex workers and poor socio-economic groups, are among the most cost effective responses.

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Annex 1: The spread of HIV/AIDS in Sub Saharan Africa 1984 to 1999

A global view of HIV infection
33 million adults living with HIV/AIDS as of end 1999

