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HIV/AIDS EPIDEMIC AND ITS SOCIO-ECONOMIC EFFECTS IN AFRICA

Akor Sunday Joseph
Department of Sociology
University of Ilorin, Nigeria
sundayjocakor@yahoo.com; +2348032055522

Abstract

HIV/AIDS epidemic is a global scourge threatening human existence. Global effort by researchers, scholars and medical experts to bring the epidemic to a halt is ongoing. Different scholars and researchers all over the world have tried to trace the origin, spread and effects of the disease. Some scholars have tagged the epidemic as "African or Black man's burden" of the century. Even though the spread of the epidemic is global in nature Africa as a developing nation has her own share of the global scourge. HIV/AIDS and the effects is visible on social, political, economic and religious life of Africa society among others. This paper describes the devastating effects of HIV/AIDS epidemic on Africa. The paper relies on the use of secondary source of data collection to point out that, the spread, effects of HIV/AIDS in Africa is on the increase despite the large amount of resource committed to fight the disease. The paper concludes that instead of over relying on the claim in some literature, news reports and Television jingles all over the world that the mortality rate, spread and effects is now at a minimal level in Africa and world-wide, a more realistic approach should be devised to bring the scourge to a halt.

Keywords: Community, Economy, Epidemic, HIV/Aids

Introduction

Various academic disciplines such as medicine, sociology, political science psychology among others have focused attention on the discourse of sexually transmitted infections (STIs). Sexually transmitted infections (STIs) have been around for a long time and in west-Africa, STIs are next to malaria in spread. But man has tackled STIs because the causes, treatment and preventive measures are known (EFFA-Heap 1997).

However, with the entrance of HIV/AIDS epidemic, all STIs have been pushed to the background. HIV means Human Immune Deficiency Virus and it is this virus that leads to AIDS at its eternal developmental stage. (Barnet and Blackie 1992). Further more, AIDS is conceptualized as,

Acquired Immune Deficiency Syndrome, it is an extremely serious disorder that results from severe damage to the body's defence against disease (Falola 2007).

HIV/AIDS epidemic as social phenomena constitutes one of the greatest medical and social challenges among others facing all the countries of the world today. The phenomenon of HIV/AIDS epidemic is a world-wide challenge to humanity. To buttress this assertion, James (1998) is of the view that, drug abuse, alcohol abuse and HIV/AIDS epidemic are some of the major burdens of societies on the 21st century. Studies and statistics have shown that globally more adolescent and teenage children constitute the majority of victims. The devastating effects or implication of HIV/AIDS epidemic cut across all fabrics of human existence. By the end of 2007 estimated figure of over 39 million people world-wide have been infected with HIV/AIDS (WHO 2007). Among this report figure, African continent alone accounted for one-third of global victims of HIV/AIDS epidemic. No doubt, available data and global report on HIV/AIDS epidemic show reduction in spread of the epidemic call HIV/AIDS yet, the devastating effects on humanity particularly in African is very obvious in all fabric of the continent.

Origin of HIV/AIDS

Global report on HIV/AIDS epidemic (2010) by UNAIDS points out that the earliest known cases of human HIV infection have been linked to western Equatorial Africa, probably in South-East Cameroon where groups of the central common chimpanzee live. According to the report, HIV/AIDS is closely associated with the preparation for human consumption of freshly killed chimpanzees. According to Shenton (1998), it was in the mid-1980s that it became widely accepted that the origin of AIDS is from Africa. The above position was first posited by Kevin Decock from the Institute of Hygiene and Tropical Medicine who pointed out that AIDS was "old disease from Africa". In his own contribution (Levy 1998) published a book titled "HIV and Pathogenesis of AID" and traced it to Africa. According to Levy (1998) the disease started somewhere in Africa about one thousand years ago (1000 years ago). To Folola and Heaton (2007), HIV/AIDS is an African challenge and concludes that the disease originated from Africa and the scourge is threatening every part of Sub-Saharan Africa with no end in sight. According to Gallin (1985) HIV/AIDS is believed to have originated in

Africa. To Garland (2003) HIV has been around since the 1950s as body tissues containing HIV antibodies. These antibodies have been found from that time both in England and Africa. To Piot et al (1988) HIV/AIDS epidemic is traceable to Africa and heterosexual transmission accounts for Africa having the highest rate of HIV/AIDS incidence in the world. According to Bongaarts et al (1989) circumcision of persons with unsterilised sharp instruments account for the origin and spread of HIV/AIDS epidemic in Africa.

Theoretical Perspectives of the Origin and Spread of HIV/AIDS in Africa

Different scholars and researchers propounded theories that offer explanation for the origin and spread of HIV/AIDS epidemic in Africa. One of such theories is called the hunter theory. The hunter theory on the spread and origin of HIV/AIDS contends that Simian Immune deficiency Virus in Chimpanzees (SIVPS) was passed to human beings as a result of killing and eating of chimps by hunters and other non-hunters in Africa, that rely on bush meat as part of their protein needs. According to Nathan (2004) in the process of killing and eating chimpanzees, the blood of Chimpanzee is likely to get into cuts or wounds of the hunter. The theory maintained that the failure of the hunters' body to fight off SIV often resulted into HIV – 1 type in human being. This hunters theory traced the origin and spread of HIV/AIDS to hunting and eating of bush meat by hunters in Cameroon and other Africa countries.

In addition to the above theory, the contaminated needle theory is another theory that traced the origin and spread of HIV/AIDS epidemic to the African continent. This theory is an extension of the original hunter theory discussed above. According to Bette Korber (1998), all over the world in the early 1950s, the use of disposable plastic syringes as a cheap, sterile way to administer medicine was the order of the day. The theory emphasizes that due to high cost involved in throwing away disposable plastic syringe after each use, African health care professionals who are directly rendering services on inoculation and other medical programmes resorted to use a single syringe to inject multiples patients without any form of sterilization process in between. The theory concludes that the use of single syringe for multiple patients is likely to be responsible for the origin and spread of HIV/AIDS in the African continent.

Another HIV/AIDS theory that traced the origin and spread of HIV/AIDS to Africa is conspiracy theory. The theory is of the view that the migration of Africans to United States of America resulted in the migration of the disease to the USA. The population of Blacks became too high for the comfort of the Americans.

According to Anne-Mieke (2003), significant number of Africa-Americans believed that in order to reduce the growing population of Blacks in America that HIV was produced as part of biological warfare programmed aimed at wiping out large numbers of blacks.

Colonialism theory or the "heart of darkness" is one of the theory used to explain the origin and the spread of HIV/AIDS. According to More (2000), the greatest part of African continent was ruled by colonial forces in the 19th and 20th century. The theory mentioned particularly Belgian Congo and French Equatorial Africa where colonial rule was very harsh to the indigenous Africans. The theory maintained that due to the harshness of colonial rule, Africans were forced into labour camps where poor sanitary conditions, scarcity of food and physical demand were prone. The theory further posits that the above enumerated factors are sufficient to warrant poor health in the life of anyone be it White or Blacks. It is the poor health conditions prevailing in the camp that made it easy for SIV to infiltrate the labour camps. Furthermore, the theory maintained that in the face of food shortage in the camp, a stray and may be sick Chimpanzee with SIV would become an extra source of food for the workers in the labour camp. According to More (2000), the labour camp was full of forced African prostitutes and it was within the period that HIV was first believed to have passed into humans.

Another controversial theory that traced the origin of HIV/AIDS to the African continent is oral polio vaccine theory by Hopper (2004). The theory posits that HIV could be traced to the testing of an oral polio vaccine by the name Chat, given to about a million people in Rwanda in the late 1950s. Hooper's view is that Chat was grown in kidney cells taken from local chimps (in Africa) infected with simian immuno-deficiency virus in Chimpanzee. According to Hopper, to reproduce live polio vaccine it needs to be cultivated in living tissue. Thus, he claims, this would have resulted in the contamination of the vaccine with Chimpanzee SIV and given room for great number of people subsequently becoming infected with HIV in Africa.

Incidence and Spread of HIV/AIDS in Africa

Africa as a continent has her own large share of the global scourge known as HIV/AIDS that has ravage and caused untold havoc in the work place homes, schools and churches. It has left the entire African continent with many orphans than ever witnessed. UNAIDS (2012) report pointed out that, although, the continent is home to about 15.2 percent of the world's population, sub-Saharan African alone accounted for an estimated 70 percent of all people living with HIV and 70 percent of all death in 2011.

The UNAIDS report (2012) further posits that, countries in North Africa and horn of African have significantly lower prevalence rate. This is so because the population typically engage in fewer high risks cultural practices or patterns that have been implicated in the virus spread in sub-Saharan Africa. Of all African countries, South Africa is the worst affected. In 2011 alone, HIV has infected at least 10 percent of the population in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Though majority of figures and statistics concerning HIV/AIDS epidemic are conflicting and contradicting, one common denominator is the fact that all figures and statistics show a very high trend of HIV/AIDS epidemic in the African continent. According to Msusa (2008), in many African countries, the first case of the pandemic which has won itself the accolade of being the leading causes of death on the continent was reported in the mid-eighties. Today it is shocking to note that the disease has left a sad trail of total devastating on the continent. According to UNAID (2007), by the end of 2007 there were an estimated people living with AIDS, a virus that causes AIDS in Sub-Saharan Africa, thus accounting for 68% of all HIV positive people in the world.

In Swaziland, the first AIDS case was reported in 1987 and today the small African country has the world's highest adult HIV prevalence rate of 33.4%. In Botswana, according to UNAID report (2007) the first incident of HIV/AIDS case was discovered in 1985 but as at now the country has 24.1% of the adult population who are HIV positive and thus making it the second highest on the face of the earth after Swaziland. Out of the country's total population of 1.6 million people, an estimated 270,000 were living with HIV in 2005 (WHO 2007). In South African country of Lesotho AIDS was first reported in 1986 and out of the total population of 2 million people, 23.2% of its adult are HIV positive (Msusa 2008). South Africa as a country is presently experiencing one of the callous AIDS epidemic. In Malawi, HIV

was reported in 1985 and since then the AIDS epidemic kills 10 people per hour (UNAID 2006).

According to Msusa (2008), the HIV/AIDS scourge has registered adverse impacts in almost all walks of life in Africa starting from households, the economy to the health sector. According to UNAIDS (2007) report, about 1.6 million people died in Sub-Saharan Africa alone leaving behind millions of orphans. African continent particularly the Sub-Saharan Africa is currently estimated by UNAID (2007) as having 9% of children who have lost at least one parent to AIDS and the implication of this, is exposing tomorrow's future leaders and generation to emotional trauma, abuse and exploitation. 9% of Zambia's total populations of children are AIDS orphans. It is estimated and predicted that by the year 2010 (UNAIDS 2007), there will be around 15.7 million AIDS orphans in Sub-Saharan Africa alone. This is expected to overstretch the traditional extended family system in Africa. According to WHO (2006) more than 90% of children living with HIV reside in Sub-Saharan Africa. The more saddening experience of Sub-Saharan HIV/AIDS epidemic is the death toll afflicted on the continent's best brains that are supposed to move the region's economy forward.

To support the above assertion, a United Nations Development Programme (UNDP 2003) concluded study in Rwanda, Burkina Faso and Uganda indicated that HIV/AIDS will not only slow down progress in poverty reduction but will also increase the percentage of those living in extreme poverty, from 45% in 2000 to 51% in 2015. The finding further stated that 25% of the working class in the study area (that is Uganda, Bukina faso and Rwanda) are living with HIV/AIDS thus paving way for the pandemic to reduce productivity through increased absenteeism.

According to Sayers (2005) in Malawi HIV/AIDS is reducing the country's agricultural workforce and output and by the year 2020 agricultural workforce will be 14% smaller than it would have been without the epidemic. In countries like Botswana, Namibia and Zimbabwe UNAIDS (2003) pegged the reduction in agricultural workforce due to HIV/AIDS epidemic at over 20%. The HIV/AIDS epidemic is also exacting pressure on Health sectors in Africa particularly on Sub-Saharan Africa. Nigeria's HIV/AIDS epidemic actually calls for concern. This is so because Nigeria is one of the most populated Black Nations of the world. The country is ranked

by the United Nations as the third highest carrier of HIV/AIDS epidemic in the world.

The first case of AIDS was identified in 1986 and report by UNAIDS indicated that by 2005 there were an estimated 2.9 million people living with HIV/AIDS in Nigeria (UNAIDS 2006). According to Arazem (2006) cited in Salihu et al (2000), Nigeria has about 8% of the global burden of HIV/AIDS. There has been a steady rise in the HIV prevalence from less than one percent in 1990 to 1.2 percent in 1991, 3.8 percent in 1992, 4.5 percent in 1995, 5.3 percent in 1999 and 5.8 percent in 2001. It is estimated that more than 3.5 million Nigerians are currently living with HIV/AIDS (FMOH 2001).

The data reproduced below gives a detailed glance of HIV/AIDS situation report in Africa.

Statistics Showing the Prevalence of HIV/Aids in Africa North Africa

Country	Adult prevalence ages 15-49 2011	Adult prevalence e ages 15 -49, 1001 ⁽¹⁰⁾	Number of people living with HIV 2011 ⁽⁶⁾	Number of people living -with HIV 2001 ⁽¹⁰⁾	Aids death, 2011 ⁽⁶⁾	Aids deaths, 2001 ⁽¹⁰⁾	New HIV infections 2011 ⁽¹⁰⁾	New HIV infections, 2001 ⁽¹⁰⁾
Algeria	0.1% ⁽⁶⁾	<0.1%	13,000-28,000	Not available	<1,000-1,500	<200-500	Not available	Not available
Egypt	<0.1% ⁽⁶⁾	<0.1%	9,500	9,100	<1,000	<500	Not available	Not available
Libya	<0.2% ⁽⁶⁾	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Morocco	0.2% ⁽⁶⁾	<0.1%	32,000	12,000	1,600	<1,000	Not available	Not available
Sudan	0.4% ⁽¹⁰⁾	0.5%	Not available	Not available	5,600	6,000	Not available	Not available
Tunisia	<0.1% ⁽⁶⁾	<0.1%	1,700	<1,000	<100	<100	Not available	Not available

Source: UNAIDS Report on the global AIDS Epidemic 2013

Horn of Africa

Country	Adult prevalence ages 15-49 2011	Adult prevalence ages 15 - 49, 1001 ⁽¹⁰⁾	Number of people living with HIV 2011 ⁽⁶⁾	Number of people living with HIV 2001 ⁽¹⁰⁾	Aids death, 2011 ⁽⁶⁾	Aids deaths, 2001 ⁽¹⁰⁾	New HIV infections 2011 ⁽¹⁰⁾	New HIV infections, 2001 ⁽¹⁰⁾
Djibouti	1.4%	2.7%	9,200	12,000	<1,000	1,000	<1,000	1,300
Eritrea	0.6%	1.1%	23,000	23,000	1,400	1,500	Not available	Not available
Ethiopia	1.4%	3.6%	790,000	1,300,000	54,000	100,000	24,000	130,000
Somalia	0.7%	0.8%	35,000	34,000	3,100	2,800	Not available	Not available

Source: UNAIDS Report on the global AIDS Epidemic 2013

Central African

Country	Adult prevalence ages 15-49 2011	Adult prevalence ages 15 - 49, 1001 ⁽¹⁰⁾	Number of people living with HIV 2011 ⁽⁶⁾	Number of people living with HIV 2001 ⁽¹⁰⁾	Aids death, 2011 ⁽⁶⁾	Aids deaths, 2001 ⁽¹⁰⁾	New HIV infections 2011 ⁽¹⁰⁾	New HIV infections, 2001 ⁽¹⁰⁾
Angola	2.1% ⁽⁶⁾	1.7%	230,000 ⁽⁶⁾	130,000	12,000 ⁽⁶⁾	8,200	23,000	20,000
Cameroon	4.6% ⁽⁶⁾	5.1%	550,000 ⁽⁶⁾	450,000	34,000 ⁽⁶⁾	28,000	43,000	57,000
Central African republic	4.6% ⁽⁶⁾	8.1%	130,000 ⁽⁶⁾	170,000	10,000 ⁽⁶⁾	16,000	8,200	15,000
Chad	3.1% ⁽⁶⁾	3.7%	210,000 ⁽⁶⁾	170,000	12,000 ⁽⁶⁾	13,000	Not available	Not available
Congo	3.3% ⁽⁶⁾	3.8%	83,000 ⁽⁶⁾	74,000	4,600 ⁽⁶⁾	6,900	7,900	7,200
Democratic republic of the Congo	1.2% ⁽⁴⁾ 1.6% ⁽⁴⁾	Not available	430,000- 560,000 ⁽⁴⁾	Not available	26,000- 40,000 (2009) ⁽⁴⁾	Not available	Not available	Not available
Equatorial Guinea	4.7% ⁽⁶⁾	2.5%	20,000 ⁽⁶⁾	7m900	<1,000 ⁽⁶⁾	<500	Not available	Not available
Gabon	5.0% ⁽⁶⁾	5.2%	46,000 ⁽⁶⁾	35,000	2,500 ⁽⁶⁾	2,100	3,000	4,900
Sao Tome and Principe	1.5% ⁽⁶⁾	0.9%	<1,000 ⁽⁶⁾	<1,000	<100 ⁽⁶⁾	>100	Not available	Not available

Source: UNAIDS Report on the global AIDS Epidemic 2013

Uganda

Country	Adult prevalence ages 15-49 2011	Adult prevalence ages 15 - 49, 1001 ⁽¹⁰⁾	Number of people living with HIV 2011 ⁽⁶⁾	Number of people living with HIV 2001 ⁽¹⁰⁾	Aids death, 2011 ⁽⁶⁾	Aids deaths, 2001 ⁽¹⁰⁾	New HIV infections 2011 ⁽¹⁰⁾	New HIV infections, 2001 ⁽¹⁰⁾
Burundi	1.3% ⁽⁶⁾	3.5%	80,000	130,000	5,800	13,000	3,000	6,900
Comoros	0.1% ⁽⁶⁾	<0.1%	<500	<500	<100	<100	Not available	Not available
Kenya	6.20% ⁽⁶⁾	8.5%	1,600,000	1,600,000	62,000	130,000	100,000	140,000
Madagascar	0.3% ⁽⁶⁾	0.3%	34,000	22,000	2,600	1,500	Not available	Not available
Mauritius	1.0% ⁽⁶⁾	0.9%	7,400	6,600	<1,000	<500	Not available	Not available
Mayotte	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Reunion	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Rwanda	2.9% ⁽⁶⁾	4.1%	210,000	220,000	6,400	21,000	10,000	19,000
Seychelles	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
South Sudan	3.1% ⁽⁶⁾	Not available	150,000	Not available	11,000	Not available	Not available	Not available
Tanzania	5.1% ⁽⁶⁾	7.2%	1,600,000	1,400,000	84,000	130,000	150,000	140,000
Uganda	7.2% ⁽⁶⁾	6.9%	1,400,000	990,000	62,000	100,000	150,000	99,000

Source: UNAIDS Report on the global AIDS Epidemic 2013

Western Africa

Country	Adult prevalence ages 15-49 2011	Adult prevalence ages 15-49, 2001 ⁽¹⁰⁾	Number of people living with HIV 2011 ⁽⁶⁾	Number of people living with HIV 2001 ⁽¹⁰⁾	Aids death, 2011 ⁽⁶⁾	Aids deaths, 2001 ⁽¹⁰⁾	New HIV infections 2011 ⁽⁶⁾	New HIV infections, 2001 ⁽¹⁰⁾
Benin	1.2%	1.7%	64,000	66,000	2,800	6,400	4,900	5,300
Burkina faso	1.1%	2.1%	120,000	150,000	6,800	15,000	7,100	13,000
Cape verde	1.0%	1.0%	3,300	2,700	<200	<500	Not available	Not available
Cote d'Ivoire	3.0%	6.2%	360,000	560,000	23,000	50,000	Not available	Not available
Gambia	1.5%	0.8%	14,000	5,700	<1,000	<500	1,300	1,200
Ghana	1.5%	2.2%	230,000	250,000	15,000 ^(Notch)	18,000	13,000	28,000
Guinea	1.4%	1.5%	85,000	72,000	4,000 ^(Notch)	5,100	Not available	Not available
Guinea-Bissau	2.5%	1.4%	24,000	9,800	<1,000	<1,000	2,900	1,800
Liberia	1.0%	2.5%	25,000	39,000	2,300 ^(Notch)	2,500	Not available	Not available
Mali	1.1%	1.6%	110,000	110,000	6,600	9,700	8,600	12,000
Mauritania	1.1%	0.6%	24,000	10,000	1,500	<1,000	Not available	Not available
Niger	0.8%	0.8%	65,000	45,000	4,000	3,200	6,400	6,200
Nigeria	3.7%	3.7%	3,400,000	2,500,000	210,000 ^(Notch)	150,000	340,000	310,000
Senegal	0.7%	0.5%	53,000	24,000	1,600	1,400	Not available	Not available
Sierra Leone	1.6%	0.9%	49,000	21,000	2,600	<1,000	3,900	4,500
Togo	3.4%	4.1%	150,000	120,000	8,900 ^(Notch)	8,100	9,500	17,000

Source: UNAIDS Report on the global AIDS Epidemic 2013

Socio-Economic Effects of HIV/AIDS Epidemic in Africa

Africa's HIV/AIDS epidemic has had important effects on the socio-economic and political nature of the continent Okunlola (2010) pointed out that Africa today are fighting the worst plague in human history and official figures indicate that over 30 million Africans are living with HIV/AIDS. The continent of Africa is inhabited by 12% of the world's population. It is estimated to have more than 60% of the world's AIDS infected population (Davidson, 2009).

In an article entitled, "the impact of HIV/AIDS in Africa" AVERT (2012) wrote: "HIV ... has cause immense human suffering in the continent. The obvious effect has been illness and death. The effects of HIV/AIDS epidemic in Africa are evident in all aspects of life. This schools, work places, and economic have also been badly affected.

The effect of HIV/AIDS on sub-Saharan Africa is such that it is people with HIV/AIDS related diseases that constitute the majority of patients in the hospital and occupy more bed spaces than others.

Avert (2012) posits that medical professional are being directly affected for example, in Botswana 17% of its health care worst force died due to AIDS between 1999 and 2005.

In addition to the above, AIDS has an enormous effects on household. It causes household to be dissolved as a result of death of parents, children are scattered and are divided among relatives to take care of. This brings about more orphans in Africa that can be adequately catered for.

The epidemic adds to food scarcity, this is so because many able bodied farmers due to AIDS related sickness abandon agricultural sector or farming. Coupled with the above effects of brings about changing roles for women most career women let their profession to cope with family burden of caring for the sick members of the family.

Another effect of AIDS in Africa is the reduction of work force. Already African is experiencing high turnover rate in the teaching profession. With high death rates among the teachers, it further reduces labour force in that sector. For example in Tanzania in 2006, it was estimated that around 45,000 make up for those who had died or left work because of HIV/AIDS.

It is also believed that HIV/AIDS damages businesses by squeezing productivity, addition to costs, diverting productive resources, and depleting skills. Also the demand and supply of goods and services based on market continue to rise and fall as a result of effects of HIV/AIDS epidemic.

In sub-Saharan Africa AIDS is reducing life expectancy. There are more death rates between 20 and 49 years of age, thus removing the very age group that can respond to the AIDS crisis.

In addition, children are being forced to become bread winners of the family in absence of their parents.

Measures for Curbing HIV/AIDS Epidemic

There are several literatures that contain data showing reduction in infection rate, death rate, abstinence from high risk factors among others. For example, a glance at the table reproduces below show a downward trend in HIV/AIDS epidemic world-wide.

Data Showing Downward Trend in HIV/AIDS Epidemic World-Wide

World Region	Adult HIV prevalence ages 15-49 2011	Persons living with HIV ⁽¹⁾	AIDS deaths, annual ⁽¹⁾	New HIV infections, annual ⁽²⁾
Worldwide	0.8%	34,000,000	1,700,000	2,500,000
Sub-Saharan Africa	4.9%	23,500,000	1,200,000	1,800,000
South and Southeast Asia	0.3%	4,000,000	250,000	280,000
Eastern Europe and Central Asia	1.0%	1,400,000	92,000	140,000
East Asia	0.1%	830,000	59,000	89,000
Latin America	0.4%	1,400,000	54,000	83,000
Middle East and North Africa	0.2%	300,000	23,000	37,000
North America	0.6%	1,400,000	21,000	51,000
Caribbean	1.0%	230,000	10,000	13,000
Western and Central Europe	0.2%	900,000	7,000	30,000
Oceania	0.3%	53,000	1,300	2,900

Source: UNIADS Report on the Global AIDS Epidemic 2013.

The data reproduced above showing down wards trends in HIV/AIDS epidemic world-wide is as a result of measures taken to reduce to the spread of the disease all over the world. There are several measure that have been put in place to curb the spread of HIV/AIDS epidemic in Africa.

One of the measures taken by various African leaders to reduce the spread of HIV/AIDS epidemic in Africa is via public education initiatives. The public education initiatives include public lectures, symposium, seminar, television jingles, newspaper advertisement etc., that emphasizes the mode of transmission, prevention, and care for victims, discouraging social stigma among others. For instance, in Tanzania, the public education initiatives include "combination prevention programmes". UNIADS (2003) defines combination prevention programmes as: right-based evidence-informed and community-owned programmes that use mix of biomedical, behavioural and structural intervention prioritized to meet the current HIV needs of particular individual and communities, so as to have the greatest sustained impact on reducing new infections.

Part of the measures adopted by most African countries to further curb the spread of HIV/AIDS epidemic is the adoption of UNAIDS "ABC" structural intervention programmes. That is, "A" – abstinence b – be faithful, c- use a condom (ABC). Some of the UNAIDS preventive measure

programmes to promote human rights, combat gender in equality and HIV related stigma and discrimination. Others include removal of punitive laws that block AIDS response. For instance in Uganda, due to increase rate in new infection, "ABC" strategy was replaced with "Combination preventive programme (Stangl 2002).

Another preventive measures use by African countries to reduce the spread of HIV/AIDS includes "total community mobilization" total community mobilization is a way of reaching out to the people with the message on how to prevent HIV/AIDS epidemic. For instance, in Botswana, Total community mobilization sent 450 AIDS counselors door-to-doors, giving preventive advice, urging HIV testing and referring infected people to treatment. Free condom distribution among the populace most especially the vulnerable groups is among the strategy adopted in Nigeria to curb the spread of HIV/AIDS epidemic. For instance, U.S. Agency for International Development and its British counterpart periodically sponsored programme aimed at counseling high risk group between the ages of 15 to 24, most unmarried, living in the city and working in semiskilled jobs on the danger of HIV/AIDS epidemic to individual, family and society in general.

Discouragement of some African cultural practices is also among the measures taken to curb the spread of HIV/AIDS epidemic in Africa. Such cultural practices include circumcision of males and female genital mutilation (particularly with unsterilized objects), multiple sex partners, stigmatizing attitudes, indiscriminate sexual behaviour etc. Another programme aimed at curbing HIV/AIDS epidemic in Africa is known as, "AIDS watch". AIDS watch was established in April 2001 in Abuja-Nigeria during African Union submit on HIV/AIDS. During the AIDS submit, heads of state and heads of government of Botswana, Ethiopia, Kenya, Mali, Nigeria, Rwanda, South Africa and Uganda established the AIDS watch Africa (AWA) advocacy platform. The initiative was formed to "accelerate efforts by Head of State and Government to implement to their commitments for the fight against HIV/AIDS, and to mobilize the required national and international resources. By the year 2012, AWA was revitalized to include all Africa and its objectives were broadened to include malaria and tuberculosis.

In addition to the above measures, prevention of HIV transmission from pregnant women to children is another step taken by African countries to reduce the scourge of HIV/AIDS epidemic in Africa. UNAIDS report

(2012) has it that in sixteen African nations, more than three-quarters of pregnant women living with HIV receive antiretroviral medicine to prevent transmission to their child.

Activities and programmes by non-governmental organizations (NGOs) all over Africa also help to curb the spread of HIV/AIDS epidemic in Africa. The programmes range from public enlightenment campaign, caring for AIDS orphans/victims, match-mating HIV/AIDS victims etc. the match-mating of HIV/AIDS victims that HIV/AIDS victims do not marry a non-HIV/AIDS victims. For instance, Bauchi State government of Nigeria sponsored the wedding ceremony of intended couples who are HIV/AIDS victims. In addition to sponsoring of the marriage programme, monetary reward is also given to the couples who are HIV/AIDS victims.

Conclusion

This paper is on HIV/AIDS epidemic and its socio-economic effects in Africa. The paper concludes that the problem that is associated with HIV/AIDS is a reality that deserves urgent attention not only in Africa but world-wide. The paper further concludes that the battle against HIV/AIDS is a global war and African countries cannot afford to be left behind. The paper therefore offers the following suggestions.

- * The current measures put in place all over the African countries to curb HIV/AIDS epidemic in Africa should be maintained or sustained and should be taken to every nook and crannies of Africa.
- * African heads of state and heads of government should be seeing the battle against HIV/AIDS as an African affair and as such, make annual budgetary allocation of funds to fight the scourge.
- * Steps should be taken all over African countries to wipe away primitive customs, laws, norms that encourage the spread of HIV/AIDS epidemic.
- * Punitive measure should be taken against medical health-practitioner that neglect or refuse to treat HIV/AIDS victims. In addition, the deliberate use of unsterilized objects by health workers should not go unpunished.
- * African government should set-up organs that can monitor, evacuate, checks and also balance the activities of Non-governmental organization (NGOs) by ensuring that funds meant for HIV/AIDS victims are not diverted to private or personal use.

- * Finally, African countries should not over rely on foreign donors funds to fight the war against HIV/AIDS epidemic.

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