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This series aims at providing lessons from recent economic research applied to Namibia relevant for policy making

Silently Starving? The HIV Epidemic and Communal Farmers

A survey carried out by NEPRU among communal farmers affected by the HIV epidemic shows dire living conditions. The majority of households surveyed are unable to feed themselves. Different strategies are being used by communal farmers to cope with a disease that shows regional and sub-regional dynamics. These strategies are not working and other forms of intervention are required.

1. Persons in communal farms affected by HIV/AIDS face hunger and extreme poverty.

Using the basic household survey tool of the NHIES 2003/04,¹ a total of 144 HIV affected households were surveyed in three regions of Northern Namibia (Kavango, Oshana and Oshikoto) during November 2004. Data was collected on household demographics, income and expenses. Four key points emerge from the analysis.

First, income and expenditure data suggest that HIV-affected households are unable to meet their basic needs. Very few households had a formal income, making agricultural production essential for creating a sustainable livelihood. However, agriculture production among HIV-affected households in the survey did not meet their own needs, with significant levels of asset stripping occurring in order to meet increasing economic needs.

According to the FAO, Namibians derive 53% of their caloric needs from grains. In the areas of the study, pearl millet (omahangu) is the staple grain. Using the caloric requirements of adult males and females, as well as the caloric value of cooked omahangu porridge, it was possible to calculate the amount of threshed omahangu an average household from the sample needed to meet the FAO estimate of caloric needs. This came to 1705 kilograms of omahangu for the average household.

The survey found that 86% of households did not produce the amount needed to meet roughly half of their caloric requirements via omahangu production. This shortfall was not filled by other crops, or by livestock. Two thirds of the sample had livestock, though the majority had numbers too small to allow for regular off-take, and thus addition to the diet. The only conclusion is that the majority of households surveyed are hungry for parts of every year.

A similar study carried out in 2003 in the Ohangwena Region found that almost 60% of HIV affected households sampled had at least one day in the previous month where they did not have food.² This study points to a loss of labor and knowledge of farming practices which in turn led to smaller fields being planted. In 2000 an analysis of the epidemic on livestock production also pointed to the loss of both labor and knowledge as factors which contribute to decreases in livestock numbers. Livestock, as an asset are likely the first to be sold once a household's medical expenses increase due to illness brought on by AIDS. Cultural practices also play a role, as a widow does not inherit her husband's livestock after he dies, instead these go back to his family.

Second, the epidemic appears to be having dynamic impacts throughout the communal farming community. As we examined historical patterns from the Sentinel Survey data in each region, a sense of dynamism is evident within the epidemic itself. While national results show an overall decline in HIV prevalence, specific sites associated with the regions surveyed indicate a mixed pattern. Some sites are in decline, others on the rise and still others showing little change. These fluctuations could be the result of mortality, actual change in behavior, failure to change behavior, migration, or statistical issues in the Sentinel Survey itself.

2. The HIV Epidemic is dynamic

There are a number of reasons why the prevalence levels may be declining in some areas. Analysis of orphans in the sample shows that the majority have lost their father while their mother is still alive. This early die-off of men may be the cause of a temporary decrease in prevalence rates at antenatal clinics, as the widowed women are not likely to become pregnant (since their partners have died and their own infection levels may reduce fertility). If these women find new partners, they may then become pregnant and return to ante natal clinics, possibly increasing prevalence rates.

Unfortunately, the Sentinel Survey does not measure behavior. It is also not clear if basic demographic information of women attending ante natal clinics is collected. These types of data would complement the Sentinel Survey, and enhance our understanding of dynamics of the epidemic. A further analysis of specific Sentinel Survey sites indicated that due to the relatively small samples collected at each site, a small number of cases can shift the results for that site. At one site which had recorded a 6% increase in prevalence from 2002 to 2004, a decrease of 10 fewer HIV positive women would have eliminated the overall increase. The potential for such small numbers to shift results of a site, points to a need to improve attendance at ante natal clinics thereby increasing overall sample sizes.

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Policy Recommendations

- ❖ The HIV epidemic has brought hunger to families in rural Namibia. These families need support that matches both their predicament and their ability to effectively use that support.
- ❖ A better understanding of the trajectories of the disease is required. Enhancements to the Sentinel Survey will be of use in this endeavour.
- ❖ Regular, national level monitoring of the socio-economic impacts of the HIV epidemic is required.

References and further reading

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