



## The Impact of HIV/AIDS on Rural Farmers' Productivity in Abuja

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### ABSTRACT

*The effect of the HIV scourge in Nigeria cannot be overemphasized, statistics shows that since the beginning of the epidemic about 2.8% of the population are affected. This seminar set out to investigate the impact of HIV/AIDS on the Agricultural sector using the rural farmers in Abuja as a case study. The paper confirmed that the impact of HIV/AIDS on the farmers and national economy is negative, substantial and, indeed, increasing. Data used in this work was sourced through group discussions, interviews, review of journals and field work. Upon analysis of data, findings showed that HIV/AIDS contributed to low productivity which ultimately culminated into food shortage. The study also showed that there are also psychological effects borne by the members of the family of the sick farmer resulting to an overall economic loss. The researcher however recommends that more emphasis should be laid on creating awareness on the disease and that poverty alleviation programmes should be targeted to address pertinent poverty situations and households.*

**Key words:** HIV, AIDS, Health Economics, Productivity

**HOW TO CITE THIS ARTICLE:** Gylych Jelilov, Emaniya Sike, Bilal Celik, Murat Akyuz, The Impact of HIV/AIDS on Rural Farmers' Productivity in Abuja, J Res Med Dent Sci, 2020, 8 (4):94-98.

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**Received:** 02/11/2019

**Accepted:** 20/07/2020

### INTRODUCTION

HIV epidemic has a disproportionate impact on children and farmers, causing high morbidity and mortality rates among infected children and orphaning as well as low farm produce on the part of farmers. Approximately 30-40 per cent of infants born to HIV, and most will die within two years. AIDS orphaned nearly 300,000 children in 2014 and since the beginning of the epidemic, more than 800,000 children have lost parents to the disease. At the end of 2018, UNAIDS estimated that 3 million children orphaned by AIDS were living in Nigeria. These orphans living in Nigeria today are less likely than any other children to stay in school and far more likely to suffer from malnutrition, ill health and social marginalization (UNAID,2018).

The threat is spreading, and conditions are ripe for the continued spread of the virus, and perhaps

even acceleration. HIV rates among high-risk groups such as commercial sex workers have exceeded 30 per cent for many years, and STD rates among the general population are high. HIV prevalence among sex workers in Abuja rose from 6 per cent in 2000 to 12 per cent in 2017. By 2018, up to 70 per cent of sex workers tested positive. A 2015 NASCP survey found that 35 per cent of sex workers were HIV-positive. Several factors have contributed to the rapid spread of HIV in a high rate of untreated sexually transmitted infections (STIs), reduction in the use of condom, poverty, low literacy, poor health status. Also, low status of women, stigmatization, and denial of HIV infection risk among vulnerable groups. Nigeria is a complex mixture of diverse ethnic groups, languages, cultures, religions, and regional political groupings, all of which are major challenges for HIV prevention programmes. General AIDS awareness, by contrast, is low. Less than 30 per cent of men and only 14 per cent of women know that condom use can prevent HIV infection. Two-thirds of adults believe they are at no risk at all of acquiring HIV, while 24 per cent of single men and women acknowledge having

exchanged money or services for sex in the past 12 months (Nigeria Demographic and Health Survey 2017). Moreover, very few Nigerians have access to basic prevention, care, support or treatment services.

While individual social behaviour such as sexual exposure and intravenous drug use largely determine the degree of vulnerability and risk of infection, there are other underlying factors, largely operative on a societal basis, that also directly or indirectly expose the individual to additional risks of infection. These factors, including cultural practices, and social and economic factors, constitute driving forces for the spread of the HIV infection. Leading ones in Nigeria include ignorance and low level of education, cultural practices including polygamy and sexual networking, the effect of poverty and lack of access to appropriate reproductive health services, particularly for young people [1]. Beyond its present impact, AIDS threatens the future by affecting most of the determinants of economic growth and poverty reduction. At the macro level, the epidemic may already be costing Nigeria as much as 0.5 per cent of per capita growth each year. At the micro level, because the majority of those affected are in their productive years as workers, farmers and parents, the welfare of households, communities, and enterprises are all in jeopardy. The likely socio-economic implications of the epidemic on human development are thus enormous [2].

HIV/AIDS has an enormous impact on infected individuals and their families, as well as on their extended family and the community at large. The impact at the individual and the household level is mirrored at the enterprise level in the case of family-businesses, micro-enterprises and self-employment. The impact begins as soon as the HIV status of a member of the household is known and is aggravated when he or she starts to suffer from HIV-related illnesses. Where a person is known to be HIV-positive, he or she is frequently the subject of stigmatization, discrimination or even hostility in the community and at work, particularly where community members and colleagues have little understanding of HIV/AIDS. Consequently, people living with HIV/AIDS are often forced to leave their jobs and are isolated in their communities. Some of them prefer to leave their community and try to make

a new beginning where they are not known [3].

Persons with HIV infection or AIDS-related illnesses frequently have no opportunity to obtain decent jobs. Their economic situation often obliges them to take on any job they can find, which may be far below their qualifications. The effect on the family is generally a loss of income and increased expenditure on medical care and funeral costs. Thus, savings are used up, assets are sold, and more money may be borrowed. In many cases, the health costs associated with HIV/AIDS eat up all the savings of a family or family business, leaving no reserves to cope with the actual loss of the person (breadwinner, business owner, etc). A case study of 25 households associated with the Ashaka Cement Company was carried out over 2000-2016. Although the primary purpose of the study was to assess the prevalence rate among workers in the factory and their family members, some of the economic impact on the households can be evaluated. Basically, even though the company paid the medical expenses for the AIDS patients, the illness still drained family resources. When all of the patients died, the family's source of livelihood was lost, creating major economic burden [4].

#### LITERATURE REVIEW

A great deal of research has been done on the impact of HIV/AIDS on households and farmer in developing countries, with emphasis on regions in East Africa. However, these impact studies tend to be specific to locations, communities, and faith orientations resulting in findings that are not readily general to the country as a whole or even to other regions. The studies are nonetheless useful because they independently establish certain commonalities that distinguish households that have encountered the disease. Also, research interest on the socio-economic impact of HIV/AIDS in Sub-Saharan Africa is intense and growing fast, but studies that focus on the conditions of individual countries and their impact on household are infrequent. The health and medical aspects of the pandemic in Africa have overshadowed the social and economic implications, and thus there is a tendency for research and analysis to focus on the former. However, lessons learned in other

developing countries are useful in determining both the research needed within the African context, and possible efficacious responses.

In a study done in South Africa by Mosanya et al [5], the impact of HIV/AIDS on individuals and households was assessed by means of a cohort study of households affected by the disease, which was then compared with a control group of unaffected households. It was conducted in two communities in the Free State province, one urban (Welkom) and one rural (QwaQwa), in which the HIV/AIDS epidemic is rife. Of the nine provinces in South Africa, the Free State has the second highest prevalence of HIV/AIDS and the second highest rate of increase in prevalence. In terms of the impact on health, the study found that people who were sick in the previous month were most likely to have used primary care, that is, government clinics, followed by private doctors. A quarter of those who were ill were admitted to hospital during their last episode. Among deaths in affected households, the commonest source of health care was government hospitals (55 per cent), followed by traditional healers (18 per cent). There is a stress on government's provision of health services to other people with other sicknesses [6]. The mean cost of health care among household members during their last episode of illness was estimated at R98 while the mean cost of health care for household members who died was estimated at R167. Among households affected by deaths, funeral costs were substantially higher than health care costs. The median cost of funeral expenses was R4000 – 5000 per death. Relatively few households reported lost income resulting from illness or death. However, this may reflect chronically ill or dying people having been unemployed for some time. Most households with ill or dying members carried a burden of caring. About 75 per cent of all those who were ill required someone to care for them at home, while 68 per cent required someone to accompany them during health care visits. Relatively few carers lost income as a result. Few carers came from outside the household (7 per cent in the case of illness and 5 per cent among fatal cases).

The most frequent responses of households to financial crises seem to be borrowing, followed by withdrawal of savings and sale of

assets. A slightly larger number of non-affected households had borrowed money in the 12 months prior to the survey. Respectively, 72 per cent and 25 per cent of the affected households that borrowed money were affected by illness and death, with only 25 per cent and 2 per cent of non-affected households, respectively, being affected by illness and death. In over 60 percent of cases, the money was borrowed from relatives and friends, while just more than 20 per cent of loans were obtained from money – or micro-lenders. A larger proportion of affected households indicated that the money was used to pay for funerals and medical expenses, whereas a larger proportion of non-affected households indicated that the money was used for education, durables, and clothing. A larger percentage of affected households had used up their savings in the previous six months. Respectively, 76 per cent and 48 per cent of households that used up their savings were affected by illness or by death, compared to 9 per cent and 0 per cent of non-affected households [7-9]. In a four-level facility survey of HIV/AIDS in Rwanda, it was found that annual per capita use of outpatient health services was 11 visits per year for people living with HIV/AIDS (PLWHA) compared with 0.3 visits among the general population. Also, annual per capita health expenditure in households was \$63 for HIV/AIDS patients compared to \$3 for non-infected households on average. Also, less than 30 per cent of households were able to meet the costs of health care from their resources.

In another study in Abuja Nigeria, it was found that the impact of HIV and AIDS at the district level study has been highly disruptive, as a significant number of highly disruptive, as a significant number of them are farmers and technocrats are dying and are not being replaced. In Karu Abuja, the former community leader and two, possibly three, of his staff have died in the past year from the disease. Mararaba village, one extension worker who was continually active farmer recently died of AIDS, signalling the downfall of the youth group [10].

#### METHODOLOGY

This section focuses on the research design, population, sample size and sampling procedures, research instrument, administration of the

instrument and method of data analysis. Research design can be defined as the plan, structure and strategy of investigation conceived to obtain answer to research questions. The research design adopted for this study is survey design. A survey research design involves collecting data from selected representatives and analysing same to obtain results which confirm or reject research questions on the study. Population of the study captures all the rural farmers Federal Capital Territory, Abuja. We will try to effect of health condition to their productivity.

A total of 40 respondents were drawn from the population. The tool used for obtaining data in this study is the questionnaire. The scaling response of the instrument was based on 4-point rating scale of:

Strongly Agreed (SA) 4

Agreed (A) 3

Disagreed (D) 2

Strongly disagreed (SD) 1

Data obtained from the questionnaire distributed was analysed using simple percentage for the analysis of the demographic data  $F/N \times 100/1$ .

Where: F= frequencies, N = number of cases

To answer the research question, the researcher used the mean scores. The formula is given as:

$$\bar{x} = \frac{\sum fx}{n}$$

Where:  $\bar{x}$  = mean score

$\sum$  = Summation

f = frequency

x = responses

n = number sampled.

**DATA ANALYSIS AND FINDING**

**Demographic data**

In this section, relevant personal information about the respondents has been presented.

Table 1 shows the distribution of respondents according to their sex. The number of male respondents who participated in the study is 20 representing 50% of the respondents sampled while the number of female respondents is 20 representing 50% of the sampled population.

Table 2 shows that the age range between 0 – 19 years were not represented. However, 15 (37.5%) of the respondents falls between 20 -39 years. Majority of the respondents falls between 40 – 59 years, while the remaining 5 (12.5%) falls within 60 years and above.

Table 3 shows that 62.5% (25) of the respondents are married and the remaining 15 (37.5%) of the respondents are single. It implies that most of the respondents are married.

**RESEARCH QUESTION**

**What are the impacts of HIV/AIDs on rural farmer’s productivity in Abuja?**

**Answering research questions**

For easy understanding of the Analysis, Strongly Agreed (SA) and Agreed (A), Disagreed (D) and Strongly Disagreed (SD) are used with the values of 4, 3, 2 and 1 attached to each of the responses, respectively.

From Table 4 above, we observed that the major impact of HIV/AIDs on farmer’s productivity tertiary education on human capital development is drop in Agricultural sector contribution to the GDP with the highest mean score of 3.45. Findings further shows that drop in farmer’s productivity, drop in food production and loss

**Table 1: Distribution of respondents according to sex.**

| Sex    | Frequency | Percentage (%) |
|--------|-----------|----------------|
| Male   | 20        | 50             |
| Female | 20        | 50             |
| Total  | 40        | 100            |

**Table 2: Age range of respondents.**

| Age          | Frequency | Percentage (%) |
|--------------|-----------|----------------|
| 0–19         | -         | -              |
| 20–39        | 15        | 37.5           |
| 40–59        | 20        | 50             |
| 60 and above | 5         | 12.5           |
| Total        | 40        | 100            |

Table 3: Marital status of the respondents.

| Marital Status | Frequency | Percentage (%) |
|----------------|-----------|----------------|
| Married        | 25        | 62.5           |
| Single         | 15        | 37.5           |
| Total          | 40        | 100            |

Source: Field Survey, 2019

Table 4: Presentation of data.

| S/N   | Statements                                      | SA (4) | A (3) | D (2) | SD (1) | FX  | $\bar{X}$   | Decision |
|---|---|--------|-------|-------|--------|-----|-------------|----------|
| The impact are  |   |        |       |       |        |     |             |          |
| 1   | Reduction in farmer’s productivity              | 80     | 30    | 10    | 5      | 125 | 3.13        | Accept   |
| 2   | Drop in food production                         | 40     | 45    | 21    | 10     | 116 | 2.9         | Accept   |
| 3   | Drop in Agricultural Sector contribution to GDP | 100    | 30    | 6     | 2      | 138 | 3.45        | Accept   |
| 4   | Loss of potential manpower                      | 40     | 15    | 30    | 10     | 95  | 2.38        | Accept   |
|   |   |        |       |       |        |     | Total=11.86 |          |
| Section/Average Mean=Total Mean/No. of Items [11.86/4=2.97] |   |        |       |       |        |     |             |          |

of manpower are collectively accepted by the respondent as the impact of HIV/AIDs on the farmer’s productivity in Abuja. The empirical evidence is shown in the table above.

**CONCLUSION**

This study investigated the impact of HIV/AIDs on the Agricultural sector, a case study of rural farmers in Abuja. This paper confirms that the impact of HIV/AIDs on the farmers and national economy is negative, substantial and, indeed, increasing. While the focus group discussion, interviews and field work show that HIV/AIDs contribute to farmers low productivity and in turn result to food short in the economy. The study also reveals that the third-party effect of HIV/AIDs far exceeds the actual impact on the sick; hence, farmers bear the greatest burden, despite other burden borne by other members of the household. Current trends in the disease among young farmers and increasing economic loss through the caregivers deserve a new attention.

Having studied the impact of HIV on the productivity of rural famers in Abuja, we wish to make the following recommendations:

That the government should do more enlightenment on the causes of HIV/AIDs.

The villagers should be educated on how to cater for people with HIV/AIDs

There should be free distribution of condoms where necessary to encourage protected sex.

Poverty alleviation programmes should follow a target-oriented approach to make them beneficial to rural farmers.

Some international aid programs should be introduced for in support to end desperate condition of joining sex sector and utilize those as work power in agricultural sector.

Economic wellbeing and productivity will increase for those steps to be taken. Federal Capital Territory (Abuja) management should be taking these steps very seriously.

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