

ECONOMIC AND SOCIO-ECONOMIC CONSEQUENCES OF HIV/AIDS IN KOWBA STATE

M. J. Igbay, A. Usman, M. A. Igbay, E. A. AMO, M. Igbay

¹Department of Economics, University of Lagos, Nigeria

²Department of Accounting and Finance, University of Lagos, Nigeria
Kwara State Planning Commission, Ibadan, Nigeria

³Department of General Studies, Federal Polytechnic of Technology, Minna, Nigeria

Abstract

Using a self-developed model of data on Life Weighted Rank Analysis, this article examined the 1998-2006, values and socio-economic consequences of HIV/AIDS in Kwara State. The results obtained revealed that the most likely cause of HIV/AIDS in the State was an elderly female from the 15-24 age group with the term "Orphan's Care" is indicated for the period of the year 2006. The results revealed that HIV/AIDS is indicated for the period of 2007-2008, as a result of the respondents' marital interaction, followed by a reduction of educational level of these products, to an educational level, state, change and reason of non-instant settings in that order. The main study was on HIV/AIDS, therefore the use of an economic model to explain the relationship between marital setting. The model shows socio-economic consequences of HIV/AIDS in Kwara State was characterized by a reduction in living both rural and in the study. This is due to increase in health care spending, psychological disease and chronic infections, a household average, unimproved, reduction in household income, reduction in living both rural and in the study and household size. In that order. These findings by the article has suggested measures that can be taken to reduce the plight of the people living with HIV/AIDS (PLWAs).

Introduction

Available data on the prevalence of HIV/AIDS in Nigeria which revealed that 5.1% of the adults in 2007 will still be in women, given the dramatic impact of the virus on the socio-economic life of the people (PRR 2005). Although statistics on one of the HIV/AIDS prevalence study in Nigeria, Kwara State, with about 2.8 percent cases in 2007, is still confronted with the problem of containing the virus because the awareness, counseling and the diagnosis are limited (NOUN/UNICEF 2007). This means a heavy burden of HIV/AIDS could be placed on the people that the disease is not just a public health problem, but it also has far-reaching consequences for the social sector and the development.

As a result, growing HIV/AIDS has led to a decrease in stability and stability which subsequently has created a development problem due to a decrease in the productivity of individuals and the countries affected. However, in the case of health care services, health insurance and capital financing (also funds needed for such an investment), low insurance and lack of the victims' deaths in quality of education, higher expenditure on managing the epidemic led by those killed by the disease, high level of poverty, food insecurity and malnutrition.

For instance, in 2005, the estimated number of AIDS victims was 44.13 million and by 2010 the cost of health care services increased because an estimate of 7.8 billion people living with HIV/AIDS is to be aware for with an average of 100 US dollars a year. AIDS (more) led to a significant decline, especially, in the life expectancy at birth. In Nigeria, the infant mortality rate and life expectancy at birth in 2007 were 100 per 1000 and 47 years respectively which are similar when compared with that of Morocco that had 60 per 1000 and 74 years respectively and 60 years at life expectancy rate. The situation is the same with the level of economic activities in the country given the level of per capita income (1000.270) which is far below that of Morocco that was 1030.840 in 2007 (154) dollars.

The report is concluding that this article would attempt to do the following questions: What are the key issues and consequences of HIV/AIDS in Katsina State? The rest of the paper is structured as follows: Section Two provides a conceptual and empirical review of HIV/AIDS, while section Three discusses the study area and provides for methodology. Section Four presents and discusses the results, conclusions and recommendations as contained in the last section.

HIV/AIDS: Conceptual identification

Meaning of HIV/AIDS

Human immunodeficiency Virus (HIV) is that virus that destroys the body's immune system and is spread through deficiency syndrome (AIDS) is the full blown acute form of all body immunity that leads to a range of various illnesses and opportunistic infections. HIV infection is caused by two strains of the human immunodeficiency virus, HIV-1 and HIV-2. HIV-1 is the main cause of the disease (and is found in different parts of the world), while HIV-2 is found predominantly in West Africa and some parts of Angola and Mozambique. When compared with HIV-1, HIV-2 is less infectious and its clinical course is slower. The disease can be HIV-1 and HIV-2 is possible. Once introduced into the human body, HIV infects mainly a subset of immune system cells, which has a molecule called CD4 and "organizes" CD4 T-lymphocytes. In addition to two species of T-lymphocytes, CD4+ T-lymphocytes (T-helper cells) and macrophages. These cells perform various

index related to the extent of feminization of the labour force (ILO). The index gauges the overall impact of the increase in women's participation in the labour force in a number of ways: (i) growth of employment opportunities for women, (ii) growth of women's wages, (iii) growth of female members in the labour force (World Bank 1997, *Compting*, vol. 1, 2002, WHO 2002).

Causes of HIV/AIDS

HIV is transmitted through sexual intercourse, blood and blood products such as unsterilized blood transfusion, use of contaminated instruments, transfused products, including, (i) needles, (ii) dental fillings, (iii) tattooing, (iv) piercings, (v) acupuncture, (vi) nose and throat packing, (vii) transfusion of plasma, (viii) contact with transfused (or) processed blood platelets or other blood components. In developing countries, a substantial proportion of women are infected by a great proportion of men, (Hollander and Rao 1992, World Bank 1997, O'Malley 2002, Robinson, et al. 2002).

According to Bozeman (2003), several biological, socio-cultural and epidemiological variables account for the spread of the HIV/AIDS. The main economic variables are, poverty, gender inequality, income inequality and the extent of labour migration. Poverty, gender and income inequality make societies more vulnerable to HIV. For instance, a poor woman will find herself at much greater risk of HIV infection than a poor man. Unequal regional development among countries as well as within countries can induce labour migration to urban areas or other countries. The resulting concentration of migrants in urban areas in projects are generally accompanied by a parallel increase in commercial sex work and, with a concomitant rise in the risk of HIV infection. The socio-cultural variables include the type of social relations, religious belief, the structure of societies and social norms. For instance, the type of sex relations, religious belief and social norms affect the relative spread of HIV among men and women. Empirical study of Asia, HIV disease spread through heterosexual relations. There are biological variables such as, the extent of commercial sex, type of sexual relations resulting in HIV infection. Key socio-cultural variables are, migration and population mobility, disease and non-disease severity, transmission, hygiene (SL) and reported sex partners or life time partners and transmission of HIV during sexual intercourse (Harrop, et al. 2007, Choudhury (Munimul) 2004).

Consequences of HIV/AIDS

As reviewed by Chakkingal (2001, World Bank 1999a), Agarwal and Owen (1994), World Bank (1995), World Bank (1997), Robinson, et al. (2002), Bell, et al. (2000), the effects of HIV/AIDS can be grouped into two categories: those associated with rising morbidity rates and those associated with rising mortality rates for particular age cohorts, especially sexually active adult aged children infected adults. The rise in morbidity has direct negative effect, reduction in labor productivity, increase in health care spending and reduction in savings. The negative effect on productivity will arise because sick or wounded workers are less productive than happy and healthy workers. Even the productivity of those who do not have

AIDS may follow the same major trends as among Florida's rural counties on a statewide basis. The health care expenditures effect is likely to reduce expenditures by households and the health care providers' organizational or health care systems to assist AIDS patients and their families in coping with deteriorating health. The effects of aging can be seen over the direct effect of higher medical expenditures which tend to reduce saving and the provision of public, life expectancy, agricultural, and health benefits of the population.

The declining income savings will depress reduction in capital formation, leading to a reduced, if not a potentially large, net flow of new net capital income on the long run. On the other hand, the gradual net immigration will be caused by AIDS will have two important demographic impacts with macroeconomic consequences. First, there will be a slower population growth rate, which will lead to a smaller population in a future day. Second, the a number of deaths from AIDS will shift the age composition of the population towards the younger age cohorts. The shifting age composition will be expected to have important effects on both aggregate supply and aggregate demand. On the supply side, the shift of the working-age population (and perhaps the participation rate) in labor force may well be reduced. The smaller working age population will directly reduce potential output. The loss to output would be reinforced by a fall in labor force productivity as the working-age age experience of the labor force declines. On the demand side, the shift in the size and composition of the population will affect the level and composition of public consumption as well as the economy's overall private and public saving rates. For example, the smaller the total number of young people available, the lower the savings on the retirement system and the overall consumption rate will be higher. Because of the foregoing structure, see also Walsh, Bush (1993); Altemus (1978); Urey (1998); Spill (1998); Altemus and Kline (1993); Clark and Haindlor (2004); Haindlor (2004).

Direkt and Haggblom (2011) and Wharm (2011) confirm that a high prevalence of HIV/AIDS include household food insecurity and high level of malnutrition among children, especially infants, who, because of the death of infected adults that are farmers, are deprived sufficient food. The death of young adults through HIV/AIDS also reduces household earning power and therefore their ability to buy food and related goods and services. Haindlor and Haindlor (2004) have a research to spend most of their crops on corn, mostly for food and other purposes, with no or very few animals for food availability. Likewise, some may be forced to abandon or forego cash or income of food raising food crops, they are using the value of official households to generate work. The loss of the production value is part of the usual methods that provide household with community help and support. Some are worked at off-farm salient upon whom depend on their families and their children raise children. The Crisis of rural agriculture, primarily due to a widespread lack of sufficient assets, lack of human capital and innovation from either banking networks (see also Haindlor and Wharm (2011)).

Prevalence of HIV/AIDS in Nigeria

As Nigeria, the first HIV seroprevalence survey established in 1991 as a means of measuring HIV/AIDS in the country. In 2007, the prevalence rate of HIV/AIDS was 4.9 per cent of the adult population, a slight drop from 5.3 per cent. But was recorded 14 years. At the state level, a 2005 survey conducted shows that all the 36 states and Federal Capital Territory, reported cases of HIV/AIDS, with the highest prevalence rate of 18.5 per cent in Abuja. As indicated in Table 1, the states with the highest prevalence rates were Zambe (18.5 per cent) and Akwa Ibom (8.5 per cent). The states with the lowest prevalence rates were Edo (1.5 per cent), Jigawa (1.8 per cent), Oyo (1.5 per cent), Sokoto (1.7 per cent) and Kebbi (1.8 per cent).

Table 1: HIV/AIDS Prevalence in Nigeria 2005

State	Prevalence Rate (%)
Abuja	18.5
Adamawa	4.2
Anambra	5.8
Armed Forces	6.4
Bauchi	4.4
Benue	5.2
Borno	10.1
Cross River	6.1
Delta	6.7
Enugu	4.4
Federal Capital Territory	18.5
Gombe	4.0
Imo	3.0
Kaduna	3.2
Kano	3.6
Katsina	2.7
Kogi	4.0
Kwara	2.5
Lagos	7.4
Niger	1.1
Nigeria	4.9
Ogun	2.5
Ondo	2.4
Oyo	1.5
Rivers	4.5
Sokoto	1.7
Yobe	4.5
Zambe	18.5

Region	SW
Subregion	SW
Division	SW
State	SW
Localities	SW

Source: Nigeria HIV/AIDS Data and Trends 2004

Study Area and Methodology

Study Area

The focus of this study is Kwara State, which was created on the 27th May 1991. The State occupies a geographically strategic position in the map of Nigeria because it is situated between Latitude 11°2' and 11°42' N and between Longitude 7°45' and 8°14' E. It is a bordering state between the Northern and Southern parts of Nigeria bounded in the North by Niger State and shares an international boundary with the Republic of Benin to the West. To its eastern border is Kogi State, while to the south it shares boundaries with the three states of Ogun, Ondo and Epe. The State is covered by the Sudan and Savanna vegetation with a mean annual rainfall and temperature of 1,200mm/year and 30.1°C respectively. The State has 25 local government areas (states, Awo, Bonawa, Ido, Fika, Dera, Ilesha, Iyede, South, Ilesa West, Ilesa East, Irepodun, Iwo, Koro, Moro, Opa, Oye, Oyo, Oyin, and Pate). The total population of the state is estimated at 2,241,000 people (NBS/C, 2004; KWSA, 2004).

Methodology

In addition to the usual secondary data, a survey-based qualitative primary data on the causes and the socio-economic consequences of HIV/AIDS in Kwara state was conducted between the 1st April and July 2005. Focus group and qualitative were used at Park General Hospital (PGL) (method see Nkomo and Mumbenge, 1991; Duvvuri et al., 2004).

Sample and Sample Selection Methods

This study was required to be a state-wide survey, to be conducted in the distribution of villages and this was in some of the people living with HIV/AIDS in Kwara State, but it was difficult to identify the people living with the virus, as we had to interact with the HIV/AIDS workers at University of Ilorin Teaching Hospital, the Kwara State Ministry of Health, as well as the coordinators of the State and Local Government AIDS, with the assistance of these staff, we were able to identify the people living with HIV/AIDS. From the administrative records available, a total of 211 of the people living with HIV/AIDS reported.

They (are) asked to complete a questionnaire that includes demographic information (i.e., gender of the respondent, age, gender, marital status, religion, educational, and occupational status), the likely causes of the disease, the common areas of food usage (e.g., for health care spending, productivity, economic, household consumption, household care, children, education, entertainment) (figure 1) and to be ready to provide a list of interviewees and/or 3-5 names of persons or addresses, institutions and/or care where they are used.

Statistical Analysis

The data collected were first examined for omissions, errors, and outliers may be due to the analysis. Descriptive statistics, such as percentages, was used to describe the socio-demographic characteristics of the respondents who were people living with HIV/AIDS in Kwana State. In describing the most likely cause(s) and most severe consequence(s) of HIV/AIDS, a Weighted Rank Analysis (WRA) was used (see Armstrong 1999). To complement this method of analysis, the respondents were asked about their perception of the causes and the consequences of HIV/AIDS through a Participatory Rapid Appraisal (PRA) method, which includes, among other methods, the use of an in-depth interview.

Results and Discussion

Table 2. Socio-demographic Characteristics of the Respondents

Characteristics	Percentage (%)
A. Location of the Respondents	
Urban area	46.5
Rural area	53.4
B. Age of the Respondents	
15-20 years	14.5
21-30 years	49.7
31-40 years	33.5
41-50 years	1.5
51-60 years	1.5
61-70 years	1.5
71-80 years	1.5
81-90 years	1.5
91-100 years	1.5
C. Marital Status of the Respondents	
Single	37.5
Married	62.5
Divorced/Separated	0.0
Widowed/Orphan	0.0
D. Education of the Respondents	
None	20.0
Primary	37.5
Secondary	42.5
Tertiary	0.0
E. Employment Status of the Respondents	

Socio-demographic characteristics of the respondents

In the course of this survey, various factors were identified as a part of the people living with HIV/AIDS in Kwara State. These factors include the location of the respondents, the age range of the respondents, their gender, marital status, religious, household size, and occupational and economic status, as indicated in Table 2. The results of the study on the socio-demographic characteristics of the people living with HIV/AIDS in Kwara State survey are: 86.6 percent of them reside in urban centers, with 56 percent of them being female, 63.7 percent of them are aged between 30 and 49 years and 66.7 percent of them are married. The study also revealed that 59.2 of them are heads of their households and 66.5 percent and 74.7 percent were self-employed and employed in public sector activities, respectively. Most of the respondents are low- and middle-income, with 8.2 percent of them earning less than ₦50,000 a year.

The implication of this finding is that HIV/AIDS in Kwara State is largely an urban phenomenon, with low-income earners and women being the most vulnerable. The study also revealed that the adult work force is the most affected, which has implications for the state's level of productivity and economic activity.

Causes and consequences of HIV/AIDS in Kwara State, Nigeria

Based on the questionnaire, some possible causes and the most common consequences of HIV/AIDS are shown in Table 3. The results summarized the respondents' possible causes of HIV/AIDS using the Weighted Rank Analysis, which produced a score for the most likely causes of HIV/AIDS in Kwara State. As revealed by the study, the most likely cause of HIV/AIDS is, generally known by the people living with the virus, being sexually transmitted, the first with 51.4 percentage score. The second cause of HIV/AIDS is, unknown to respondents, to be a result of the virus it takes for some to manifest into a full-blown AIDS. The respondents of some of the respondents, such as women, with the percentage that responded "not known". To them, they always suspect how they contracted the disease. The second most likely cause of HIV/AIDS is through sexual intercourse with a percentage score of 15.5 percent, and this is the second most likely cause of HIV/AIDS in Kwara State. Other causes of the disease that are related with it, which in many instances, is a common practice that are a high priority to be studied as a result of the virus. Transmission of a contaminated blood or blood product, contact of contaminated needle, blood clippings, reuse of contaminated syringes on the same, shared and ill-used razor, possible causes of HIV/AIDS, respectively. The most likely cause of HIV/AIDS is the reuse of contaminated syringes, of equipment to make a viral or viral medical culture.

	100	100.0
	8.13	8.13
	Miscellaneous	1.1
B	Major Office Dept.	
	Phone	23.3
	Postage	14.3
	Printing	1.2
C	Special Health	
	Travel	
	Auto	4.1
	Auto Ins.	88.1
	Automobile	16.5
	Medical	
	Medical	
	Medical	88.1
	Medical	18.3
	Medical	
	Medical	
D	Board of Examiners	
	Board of Examiners	11.4
	State Board of Health	41.7
E	Commissioner's Special Office Expenses	
	Auto Insurance	24.1
	Department of Health Services	1.1
	Department of Public Health	1.2
	Travel	13.3
	Telephone	7.1
F	Commissioner's Special Office Expenses	
	Medical	17.4
	Medical	15.4
	Medical	13.1
	Medical	30.3
	Medical	
G	Health of Communities	
	Law and Order	20.1
	Medical - Health	4.3
	Medical - Health	26.1
H	Commissioner's Special Office Expenses	
	Auto Insurance	10.1
	Auto Insurance	10.1
	Auto Insurance	11.1

Source: 1988-89 Connecticut Statewide Telephone Survey

Table 4 summarizes the results of the multivariate socio-economic consequences of HIV/AIDS in Kenya. Starting with the Woodford Rank Analysis, the most serious consequences of HIV/AIDS in Kenya, apart from the economic contribution having been raised first, with 45.5 percentage score, followed by increase in child spending with a score of 12.8 percent. Psychological distress is not a direct indicator of household socio-economic conditions, indicated in household income reduction, in labor productivity, and the negative effect that on children education are Child Rank, FFE, and the overall results. The low overall consequence is the negative effect it has on household care.

The perception of several of the respondents was better correlated with the findings above. For example, increase in health care spending experienced by some of them was a result of loss and recovery of their existing health and the need to regularly visit the clinic and a hospital visit, which is expensive, and for drugs which has just been made free to them. This vulnerability is revealed by the grade B as a result of distress and worried psychological distress that comes with HIV/AIDS. The status of the widows, they are already faced with the problem of shortages of job, very few and mainly primarily because of discrimination, lack of skills and skills, and as a result of a rising awareness at the household and community levels. Some of the men among them have also lost their jobs because they were HIV positive. There was a case of a man driver who lost his job from the fear by the owner of the taxi that he might be infected with HIV by the driver because he has. There was also the case of a woman who was divorced by her husband and was asked to take her children along with her because of the fear that her children will also have been infected with the virus.

Table 2: Most Probable Causes of H1N1/AIDS in Kerala State

S/N	M1	M2	M3	Total Score Per Cause	Year	Total No. of H1N1/AIDS	Total No. of H1N1/AIDS	Correlation Rank (CR)
1	3	5	1	9	1	1	10	10
2	3	3	4	10	2	4	10	10
3	4	1	1	6	10	10	10	10
4	1	1	1	3	10	10	10	10
5	1	1	1	3	10	10	10	10
6	1	1	1	3	10	10	10	10
7	1	1	1	3	10	10	10	10
8	1	1	1	3	10	10	10	10
9	1	1	1	3	10	10	10	10
10	1	1	1	3	10	10	10	10
11	1	1	1	3	10	10	10	10
12	1	1	1	3	10	10	10	10
13	1	1	1	3	10	10	10	10
14	1	1	1	3	10	10	10	10
15	1	1	1	3	10	10	10	10
16	1	1	1	3	10	10	10	10
17	1	1	1	3	10	10	10	10
18	1	1	1	3	10	10	10	10
19	1	1	1	3	10	10	10	10
20	1	1	1	3	10	10	10	10
21	1	1	1	3	10	10	10	10
22	1	1	1	3	10	10	10	10
23	1	1	1	3	10	10	10	10
24	1	1	1	3	10	10	10	10
25	1	1	1	3	10	10	10	10
26	1	1	1	3	10	10	10	10
27	1	1	1	3	10	10	10	10
28	1	1	1	3	10	10	10	10
29	1	1	1	3	10	10	10	10
30	1	1	1	3	10	10	10	10
31	1	1	1	3	10	10	10	10
32	1	1	1	3	10	10	10	10
33	1	1	1	3	10	10	10	10
34	1	1	1	3	10	10	10	10
35	1	1	1	3	10	10	10	10
36	1	1	1	3	10	10	10	10
37	1	1	1	3	10	10	10	10
38	1	1	1	3	10	10	10	10
39	1	1	1	3	10	10	10	10
40	1	1	1	3	10	10	10	10
41	1	1	1	3	10	10	10	10
42	1	1	1	3	10	10	10	10
43	1	1	1	3	10	10	10	10
44	1	1	1	3	10	10	10	10
45	1	1	1	3	10	10	10	10
46	1	1	1	3	10	10	10	10
47	1	1	1	3	10	10	10	10
48	1	1	1	3	10	10	10	10
49	1	1	1	3	10	10	10	10
50	1	1	1	3	10	10	10	10
51	1	1	1	3	10	10	10	10
52	1	1	1	3	10	10	10	10
53	1	1	1	3	10	10	10	10
54	1	1	1	3	10	10	10	10
55	1	1	1	3	10	10	10	10
56	1	1	1	3	10	10	10	10
57	1	1	1	3	10	10	10	10
58	1	1	1	3	10	10	10	10
59	1	1	1	3	10	10	10	10
60	1	1	1	3	10	10	10	10
61	1	1	1	3	10	10	10	10
62	1	1	1	3	10	10	10	10
63	1	1	1	3	10	10	10	10
64	1	1	1	3	10	10	10	10
65	1	1	1	3	10	10	10	10
66	1	1	1	3	10	10	10	10
67	1	1	1	3	10	10	10	10
68	1	1	1	3	10	10	10	10
69	1	1	1	3	10	10	10	10
70	1	1	1	3	10	10	10	10
71	1	1	1	3	10	10	10	10
72	1	1	1	3	10	10	10	10
73	1	1	1	3	10	10	10	10
74	1	1	1	3	10	10	10	10
75	1	1	1	3	10	10	10	10
76	1	1	1	3	10	10	10	10
77	1	1	1	3	10	10	10	10
78	1	1	1	3	10	10	10	10
79	1	1	1	3	10	10	10	10
80	1	1	1	3	10	10	10	10
81	1	1	1	3	10	10	10	10
82	1	1	1	3	10	10	10	10
83	1	1	1	3	10	10	10	10
84	1	1	1	3	10	10	10	10
85	1	1	1	3	10	10	10	10
86	1	1	1	3	10	10	10	10
87	1	1	1	3	10	10	10	10
88	1	1	1	3	10	10	10	10
89	1	1	1	3	10	10	10	10
90	1	1	1	3	10	10	10	10
91	1	1	1	3	10	10	10	10
92	1	1	1	3	10	10	10	10
93	1	1	1	3	10	10	10	10
94	1	1	1	3	10	10	10	10
95	1	1	1	3	10	10	10	10
96	1	1	1	3	10	10	10	10
97	1	1	1	3	10	10	10	10
98	1	1	1	3	10	10	10	10
99	1	1	1	3	10	10	10	10
100	1	1	1	3	10	10	10	10

H1N1 virus (Influenza A), Malaria, Dengue, Typhoid, Strep Throat

Source: Author's compilation from various sources (2010-2015)

Table 1) How Perceived Changes in Revenue Share
 PREDICTS

	M	M1	M2	M3	Total Increase in efficiency	Total Gain of 100 MB	Total Gain of 100 MB	Cumulative Total Gain (M1)
Constant		1	2	1	1	1	1	1
1. Small increases	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
2. Small decreases	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
3. Small increases and decreases in revenue share and inefficiency	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
4. Increase in revenue share and inefficiency	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
5. Decrease in revenue share and efficiency	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
6. Increase in revenue share and efficiency	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total		100	100	100	100	100	100	100

MB = 100 million dollars, M1 = 50 million dollars, M2 = 100 million dollars, M3 = 150 million dollars.
 Source: authors' computations from Johnson et al. (2007)

Table 4: Most serious and economic consequences of HIV/AIDS in Kwara State
PERCENTAGE

VARIABLE	S	LOS	A	LS	Total Name for Expenditure of HIV/AIDS			Total	Ratio: Name for Expenditure of HIV/AIDS	Candidate Total: No. of Candidates
					S	A	LS			
1. Reduction in Life and Livelihood	15	41	11	49	114	23	177	11.1	16	
2. Decrease in Health Spending	15	21	21	46	21	44	112	11.2	21	
3. Reduction in Household Savings (1 year or more)	15	51	51	54	145	62	208	12.1	41	
4. Reduction in Household Income	15	29	26	25	119	64	184	11.9	31	
5. Effect on Household Loan	15	42	25	11	41	144	185	11.9	21	
6. Effect on Children Education	15	14	24	16	105	48	153	11.4	11	
7. Effect on Home Savings	15	14	11	21	44	22	66	11.4	11	
8. Effect on Health Spending	15	21	29	51	21	54	136	11.6	11	
9. Effect on Health Spending	15	21	29	51	21	54	136	11.6	11	
Total							1121	11.2	112	

HIV/AIDS: Socio-Economic Consequences of HIV/AIDS in Kwara State
 Source: Author's Fieldwork, from January 2001

Table 5: Access to Medical Attention and Frequency of Visits for Medical Attention by People Living with HIV/AIDS in Kerala State

	Frequency	Percentage (%)
A. ACCESS TO MEDICAL ATTENTION		
Visited for Medical Attention		
Yes		88.9
No		11.1
B. FREQUENCY OF VISITS TO MEDICAL ATTENTION		
Variable		
Daily/Once a Week		44.2
Every Six Months		1.1
Never		54.7

Source: Author's Original Survey Data for Kerala, 2007.

The study also revealed that 88.9 percent of the people living with HIV/AIDS in Kerala State had access to medical attention and 84.1 percent of them visited the nearest available medical services which is the University affiliated Teaching Hospital, because of its accessibility, quality of service and availability of diagnostic test and drugs. The risk of delay in seeking the services, however, is especially those living in rural areas, was because of distance, time and cost of travel to the Teaching Hospital, which seems to be the only one providing the diagnostic test, drugs and care.

Recommendations and Conclusion

Recommendations

Based on the findings of this study, the following recommendations are made:

- a. All factors causing HIV infection should be eliminated through enlightenment campaigns and education. The expansion of social infrastructure facilities in the rural areas and in urban slums is made to enable the kind of people from one place to the other and the ease of separation. The legislation should be such that would prevent the use of makeshift local barbers, sex workers, local instruments and traditional practices such as penis sheath especially in the rural areas, that are more vulnerable to the spread of the disease. There should also be legislation on sex workers.
- b. To achieve for some governmental efforts in prevention, detection and treatment, the State Budget will be properly divided to meet up with a legislation that would increase the provision of a disease fund that that 10 percent of the funds budgeted to the health sector for HIV/AIDS care services, especially for low income earners that are living with the disease, as well as HIV/AIDS service organizations that provide cash and grant support and assistance to those living with the disease.

- To ensure that a curriculum at the school level, based on national legislation that would require all schools to introduce into their curricula the subject of HIV/AIDS.
- School curricula on and campaigns against the people living with HIV/AIDS have taken a critical dimension in the State. The State House of Assembly should also pass laws against them and enforce their laws through relevant ministries.
- The government (NCD) should enforce the practice of mutual and the "condom culture" (condom) and marriage. It has equally HIV/AIDS should work on the and require all the citizens that "HIV/AIDS can be managed" (condom) for those who are infected. This is important given the rates of death already recorded, more for those infected the local with HIV/AIDS that consequences which are often deadly sometimes making for medical assistance.
- Families and programme on HIV/AIDS should go beyond care and support for the infected to include prevention. This is because any country that is developed and a rigorous efforts are, the devastating impact of HIV/AIDS will remain unaltered.
- The State government should work on a high priority to reduce poverty level in the state. This is because certain conditions like a strong positive behavioural change can be attained. For example, economic empowerment for the lowly paid and the most vulnerable, most of the workers is essential. Removing institutional burdensome to the workers and promotion of small and medium scale enterprises and rural credit is necessary. Promoting women's education and enhancing their status is also essential in preventing and reducing the spread of HIV/AIDS in the State.
- The government of the State should also provide equal access to preventive resources, social services (like health care, safe water, food and sanitation services, social services, and diagnostic equipment and drugs in all local areas in the state) at the local government level, given the 27 million faced by those infected with the disease in the rural areas. In this connection, improved services should be furnished for the people in the rural areas. Because it is believed that the more people living with HIV/AIDS have to these facilities, the longer they are likely to live.
- Equally important, the prevention and management of HIV/AIDS in the State should be viewed as a responsibility of joint government.

Conclusion

This report provides a snapshot of the state of HIV/AIDS:

1. HIV/AIDS in Kogi State is an acute public health problem that has increased the number of the people living with severe clinical cases.
2. The substantial increase in severe clinical cases is associated with a steady decline in condom use; and by the implication, a fall in the State's productivity and economic activities.
3. Most of the people living with HIV/AIDS in the State did not know how they got infected. However, most of the infected women did not take any sexual interventions. Two major health facilities were either closed or critically ill.
4. The most severe consequence in the study area was discrimination/stigmatisation that led to loss of jobs, divorce, rejection and exclusion from family members at the household and community levels, followed by increase in spending on health care services, which affected spending on other household needs.
5. Majority of the people living with HIV/AIDS in the urban areas had access to medical attention, while those in the rural areas have limited access to medical attention.

End Note

The 4 Local Government Areas selected from the three Senatorial Districts of Kogi State gave us a total of 32 Local Government Areas, which included the following: Doko, Epeka, Oka, Okpara, Fako, Turin South, Turin West, Iperuwa, Iba, Gweru, Uba, Uba North and Uba.

Acknowledgements

We wish to acknowledge the massive contributions of the following people in the preparation of this report: Mr. Salimata Lawal, Assistant Director in charge of HIV/AIDS control services in the Kogi State Ministry of Health, Iba, Nigeria and Mrs. Chiforah G. Igbu, Laboratory Technician in the Department of Haematology, University of Iba, Teaching Hospital, Iba, Nigeria.

References

- Abel-Smith, R. (1979) *Education and the State: A Study in the United Kingdom 1970-1978*. (HARVARD, North Providence, Rhode Island, printing) pp. 75, 86, 111. (Oxford, MA: Basil Blackwell, 1984). (ISBN 0-631-114-11-1, Distributed by Basil Blackwell, Oxford, 1984.)
- Association for the Study of Educational Policy (1990) *Review of the ASEP Study: Monday 15th June 2000*. (London: ASEP) and *CEP/SEP Schooling: A Long and a Lifetime*. (London: Institute for Education, Monday 15th June 2000).
- Association of Education Reformers (1994) *Education: A New National Charter for the 1990s*. (In: *Journal of Public Finance and Taxation*, 1994, 1(1), pp. 1-12.) (London: Association of Education Reformers, 1994.)
- Association of Education Reformers (1995) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 1995.)
- Association of Education Reformers (1996) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 1996.)
- Association of Education Reformers (1997) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 1997.)
- Association of Education Reformers (1998) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 1998.)
- Association of Education Reformers (1999) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 1999.)
- Association of Education Reformers (2000) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2000.)
- Association of Education Reformers (2001) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2001.)
- Association of Education Reformers (2002) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2002.)
- Association of Education Reformers (2003) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2003.)
- Association of Education Reformers (2004) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2004.)
- Association of Education Reformers (2005) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2005.)
- Association of Education Reformers (2006) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2006.)
- Association of Education Reformers (2007) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2007.)
- Association of Education Reformers (2008) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2008.)
- Association of Education Reformers (2009) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2009.)
- Association of Education Reformers (2010) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2010.)
- Association of Education Reformers (2011) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2011.)
- Association of Education Reformers (2012) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2012.)
- Association of Education Reformers (2013) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2013.)
- Association of Education Reformers (2014) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2014.)
- Association of Education Reformers (2015) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2015.)
- Association of Education Reformers (2016) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2016.)
- Association of Education Reformers (2017) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2017.)
- Association of Education Reformers (2018) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2018.)
- Association of Education Reformers (2019) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2019.)
- Association of Education Reformers (2020) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2020.)
- Association of Education Reformers (2021) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2021.)
- Association of Education Reformers (2022) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2022.)
- Association of Education Reformers (2023) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2023.)
- Association of Education Reformers (2024) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2024.)
- Association of Education Reformers (2025) *Education: A New National Charter for the 1990s*. (London: Association of Education Reformers, 2025.)

Keatinge, P., Mpingu, M., Carr, J., and Poffenberger, M. (2002) *Country Case Studies for Agricultural Extension*. Washington, DC: IFAD.

Ngũgĩ, J. (2006) The Kenyan AIDS epidemic: An African journal published in the United Kingdom. *Journal of the AIDS Society*, 11(1), 1-10. Available at: <http://www.aids-journal.com> (accessed 15 July 2008).

Shah, M., D. A. Austin, J. and J. P. M. (eds) (2002) *The Health and Medical Sector Impact of IFAD/CTF in the African, Latin and North America*. With technical contributions by C. Cook. World Bank Policy Review Working Paper No. 172.

Squire, L. (1998) *Combating Aids: AFR Policy Study*. Washington, DC: IFAD.

Tang, J. (2006) *Overview of AIDS/STI Epidemics in Nigeria*. <http://www.aidsinfo.org>

Wallerstein, I. and R. (eds) (1991) *Globalization and Development: A New Paradigm for Developing Countries*. *Handbook for Policy Makers, Managers and Researchers*. World Bank/IFAD Development Studies, The World Bank, Washington, DC.

Wallerstein, I. (2001) *Worlds of Difference: Development, Crisis, and Change*. London and New York: The London School of Economics and Political Science, Centre for Global Development Studies, Policy Studies Unit. Available at: <http://www.policy-studies.org>

World Bank (1994) *Improving Health Sector Development: A Guide*. United Nations Press, New York.

World Bank (1998) *The Private Sector in Health: A Guide for Policy Makers*. Washington, DC: IFAD.

World Bank (2001) *AIDS and Development: A New Paradigm for Developing Countries*. The World Bank, Washington, DC.

World Bank (1991) *Empowering AIDS: Aids Policies and Social Systems*. New York: Oxford University Press.

World Health Organization (2001) *AIDS Prevention and Control*. New York: WHO.