academicJournals

Vol. 5(5), pp. 153-162, August, 2013
DOI: 10.5897/IJSA2013.0448
ISSN 2006- 988x © 2013 Academic Journals
http://www.academicjournals.org/IJSA

International Journal of Sociology and Anthropology

Full Length Research Paper

Socio-demographic profile of people living with HIV/AIDS (PLWHA) in Idoma land, Benue state, North-central Nigeria: Implications for HIV/AIDS control

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Accepted 10 June, 2013

The profile of PLWHA constitutes a subject of interest in HIV/AIDS control initiatives. This study investigated the socio-demographic attributes of PLWHA in Idoma land, Benue State [Nigeria], with a view to suggesting customized measures for HIV/AIDS control. A total of 133 PLWHA and 25 relatives of PLWHA selected from two HIV/AIDS treatment centres provided the data through a survey questionnaire. Health workers and community/group leaders similarly provided information through IDIs and FGDs on their perceptions on those mostly inflicted by HIV/AIDS. Existing hospital records of HIV screening/admissions were also used. Data collected were analysed descriptively and thematically. Findings showed that PLWHA in Idoma land were predominantly young married farmers and females with low level of income and formal education. Many once married or unmarried PLWHA still intend to remarry or marry respectively; male PLWHA were more likely to desire remarrying. It is concluded that young female and farmers with low educational status and low income are more afflicted by HIV/AIDS. Measures to empower women and young people economically and socially are recommended, in addition to other HIV/AIDS control measures, including mass education tailored toward these more vulnerable groups.

Key words: People living with HIV/AIDS (PLWHA), socio-demographic profile, Idoma land, Benue State, Nigeria, HIV/AIDS control measures.

INTRODUCTION

Poor quality of life is implicated in the propagation of HIV/AIDS, and the burden of the disease is disproportionately felt more by those in lower socio-economic groups. Society's resources are channeled towards the maintenance of interests of the powerful over and above the societal goals of securing and improving public health. This is often reflected in the fact that the lower the social status of the person or family, the less access they have to adequate health care (Marmot, 2003; Place, 2000). The prevalence and impact of disease and illness on society as a whole is thus linked to the differential social environment in terms of health inequality and risky behaviours (Naidoo and Mills, 2001).

The human immunodeficiency virus (HIV) is currently the world's leading cause of the sexually transmitted infection (STI) – AIDS, with at least 10 persons being infected with the virus every minute globally, two-third of these in sub-Saharan Africa (FMoH, 2010). In Africa, Nigeria ranks third after South Africa and Zambia in HIV prevalence, with the prevalence rising from 1.8% in 1991 to 5.8% in 2001, and a decline from 4.4% in 2005 to 4.1% in 2010 (UNAIDS/WHO, 2011). Studies on the socio-

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characteristics of people living with HIV/AIDS (PLWHA) have shown that the most vulnerable segments of the population, that is, women, the young including children (IHVN-ACTION, 2009), and those living in rural areas (Oke, 1999), constitute the majority of those infected with the virus. Other scholars refer to these vulnerable groups of people as "those who are politically and economically disadvantaged" (Hellandendu, 2001:5). He linked the propagation of HIV/AIDS to political and economic dominance-subservience relationships, and the emergent deviant sex subculture in the developing countries. According to him, political and economic situations that force young people, mostly young females, into transactional sex or outright prostitution as a means of livelihood contribute significantly to the high prevalence of the disease in many communities.

The risky behaviours of some PLWHA have been explained by economic situations. According to Hogan (2006), economic determinism, as a most source of human motivation, is the basis for explaining social behaviour. Porter (1998) asserts that the material conditions of people determine their behavior. This materialist perspective was earlier linked human problems by Marx: looking at human challenges in the light of "real conditions of human existence, especially those related to satisfaction of simple economic and material needs" (Marx in Morrison, 2006:41). Where the economic survivals become difficult, human beings adopt different options to achieve their basic needs, indicating the correlation between behaviour and economic materialism. Thus in the case of the HIV/AIDS epidemic, the HIV positive individual's risky behaviour is a function of the socio-economic situation of the society (Naidoo and Mills, 2001). The lowest class or the poor tend to engage in more risky behaviours (such as casual, unprotected sex and substance abuse) than others as a 'rational response' to their circumstances. Such risky behaviours provide a means of 'relief' (Haralambos et al., 2006). These behaviours correlate with HIV spread, indicating higher prevalence rates in the impoverished stratum of society.

Clandestine sex workers (CSW) mainly by young women and, recently men (men to men sex – MSM) in search of economic activities and migrant labourers are particularly vulnerable. Some use themselves (their bodies) as commodities for transaction or engage in certain behaviours to cope, thus becoming prone to STIs and HIV/AIDS (Porter, 2008). Highly placed males such as company executives, lecturers, and other more favoured men equally lure females in need of favour into sex with little option to negotiate safe sex. The risk of transmission of HIV has also associated with breast-feeding (Gillespie, 2005) and female genital mutilation (FGM) (Oyefara, 2013). FGM is widespread in the country in places like Benue and Ondo States but among the Idoma, FGM is not a common practice.

The HIV/AIDS epidemic has also been foreseen from the onset as a "public health crisis" (Foster, 1986). The distribution of HIV/AIDS among population thus has implications for public health and the social structures of the community such as the family and marriages. This situation has been viewed by Barnett and Blaikie (1991) as an 'impending disaster', a tilt toward the disaster theory (Foulkes, 2010). HIV/AIDS may become a threat to the foundation of the Idoma nation as a people, since family life among the Idoma is anchored firmly on procreational marriages. In addition, the subsistent agrarian Idoma land is characterized by low socio-economic status, for example, high poverty levels (Hilhorst et al., 2004).

The foregoing seems to suggest that HIV/AIDS thrives more among the socially disadvantaged and the economically subservient groups such as the young, the female and unemployed. The main objective of this study is to determine the socio-demographic attributes of people living with HIV/AIDS (PLWHA) in Idomaland, an economically weak society, with the aim of suggesting how these will guide measures in HIV/AIDS control in the study area.

METHODOLOGY

Study site

The Idoma land [Nigeria] was selected for this study following the reported high prevalence of HIV/AIDS (*The Sunday New Nigerian* Editorial 2000; FMoH 2007). Made up of nine Local Government Areas, namely Otukpo, Okpokwu, Oju, Obi, Agatu, Ohimini, Ado, Apa, and Ogbadibo, with Otukpo as its Headquarters (Handbook on Otukpo Local Government, 1990; ICD, 2009), the district is predominantly rural and agrarian. The major ethnic group is Idoma; a homogenous ethnic group with dialectical differences indicated in three distinct speech forms of people (Otukpo, Adoka and Ugboju dialect, the Edumoga, Otukpa and Orokam dialect and Agila and Agatu dialects (Ochigbo, 2008). These three ethnic grouping often represent the political division of Idoma land along which facilities and services, including health care services, are distributed. In the traditional Idoma, marriage is usually polygynous.

Sample and sampling procedure

Site and community selection

The three dialectical clusters of Idoma land are politically divided into the Idoma West (i.e. the *Idoma Enone* made up of Okpokwu and Ogbadibo LGAs), Idoma North (i.e. the *Idoma Icho* including the Otukpo, Ohimini, and Agatu LGAs) and the *Agila-Igede cluster* (consisting of Ado, Obi , Oju, and Apa LGAs) (ICD 2009). These formed the target sites for the study. One local government area was purposively selected from each of the three clusters, based on availability of HIV/AIDS care services/treatment centres, although one of these did not have functional HIV services facility the IDIs with health and community/group leaders was necessary. The selected LGAs were then stratified into rural and urban settlements (the urban being the local government headquarters while one of the other districts from each local government area represented the rural areas). The urban areas were included purposively based on the presence of HIV/AIDS care support groups, and treatment centres and activities at the headquarters. Most general hospitals usually situated at the local government headquarters, have HIV/AIDS care and treatment facilities; HIV/AIDS Support groups

exist in the local government headquarters as well.

Sample selection

One hundred and twenty two PLWHA, made up of 97 from Centre A and 25 from Centre B, were selected through availability method. Eleven other PLWHA from Centre A (which formed two FGD groups of male and females) were selected by convenience. They were recruited from two groups: those who were in support groups (the 'organised' group) and those who were not in any support group. They were all accessed at the treatment centres. Only those willing to participate formed the sample.
Nine health workers, including two monitoring and evaluation (M&E) officers were also selected purposively as key informants.

Data collection

The researcher visited and administered a questionnaire over a two-week period. Both quantitative and qualitative data were collected on the socio-demographic characteristics of PLWHA through questionnaires for PLWHA and PABA and in-depth interviews with the Zonal Coordinators of HIV/AIDS programmes as well as Monitoring and Evaluation (M and E) Officer at the HIV/AIDS Treatment Centres A and B.

The researcher was linked with the 'organised' PLWHA groups in each of the selected treatment centres/ hospitals and/or HIV/AIDS Support Groups, from where a sample of PLWHA was drawn. Qualitative data were collected through FGDs and IDIs. All the in-depth interviews and focus group discussions were conducted by the principal investigator. Two focus group discussions, using a guide for the discussion, were conducted with eleven *HIV/AIDS Patients:* one group with five males and the other with six females (at one of the treatment centres) to complement the survey data. The PLWHA were accessed with the assistance of the Chairman and Secretary of Care Support Group. Similarly, seven PLWHA were individually indepthly interviewed at the Counselling Unit of one the hospitals.

In addition, nine health workers in the three selected health care units were interviewed as key informants. They included a medical director, two heads of nursing units, an administrative head of a hospital, two HIV coordinators of LGAs, two Monitoring and Evaluation officers of treatment centres, and one expert working in VCCT unit from one of the hospitals in the three local government areas. The health workers provided information on the observed profile of PLWHA at treatment environments (hospitals and HIV treatment centres).
Hospital HIVAIDS records were also collected for about five years at one centre and four years at the other. The Monitoring and Evaluation (M and E) Officers of the two centres were approached through their respective heads of hospitals. From Centre A, records for 2002, 2003, part of 2004, 2007, 2008 and 2009 were manually sorted and retrieved. The M&E officer and the staff of the General Hospital Medical Records department assisted to retrieve the information based on the proforma developed by the researchers.

At Centre B, records from late September 2006 (when the treatment centre commenced services at the centre) to December 2010 were electronically retrieved. The M&E officer in charge of such records assisted to get the records of screening tests, including the antenatal prevalence rates for pregnant women attending Antenatal Clinics (ANCs) within the period.

Ethical considerations

Ethical approval was given by authorities of the selected hospitals in the LGAs and the Medical Director of Centre A to both health records at the centre. Personnel at Hospital Records Department, HIV/AIDS Treatment centres and the Monitoring and Evaluation Office at the Treatment Centre assisted the researchers to retrieve relevant information. At Centre B, the hospital administrator also gave express approval and personally introduced the principal investigator to all the relevant units for data collection. At both centres, the principal investigator had first round of meetings with PLWHA and their support groups, where the purposive of the study was explained to them. Only the willing PLWHA participated in the study after giving consent. Similar meetings were held over the two-week period of data collection on different Clinic Days. The coordinators of the Care Support Groups assisted to organize willing participants for the FGDs. All the FGD participants were transported to and fro the treatment centres. Community/group leaders also granted interviews to the first author following several visits to their domains but most of the health workers agreed to give information on first contact with them at their offices.

Data analysis

Data from the survey questionnaire were edited, coded and entered in the computer coding sheets. These were processed with *SPSS version 17* (Statistical Package for the Social Science Version 17.0) to create frequencies, measures of association such as the chi square. Information from the IDIs and FGDs were transcribed. All the qualitative data were transcribed and then sorted according to the research objectives, to enable the investigator to pool ideas and statements under a particular code to illustrate the life situations of PLWHA. Records of HIV screening, both routine tests including antenatal screening, and suggested tests, from the two treatment centres were analysed. Both quantitative and qualitative information were synergized to meet the study objectives.

RESULTS AND DISCUSSION

Ethnic groups, marital status, educational level, religious and occupational affiliations

Table 1 indicates that most of the PLWHA are Christians (86.1%) of the Idoma extraction (61.5%) engaged mainly in trading/business and farming activities (53.3%), with secondary school as the highest educational qualification. Half of the PLWHA (50.0%) were married, with an average of 9.5 years of marriage. The predominance of Idoma is related to the study area which is mainly an Idoma settlement.

From Table 1, data on married PLWHA also indicates that majority 37.7% (23) are young marriages, married for 1 to 5 years, 21.3% (13) for between 6 to 10 years, 14.8% (9) 11 to 15 years while the rest have been married for between 16 to 35years. It is likely that with a mean of almost 10 years duration of marriage, most of the PLWHA have HIV infected partners.

Some married male PLWHA had more than one wife or had remarried after dissolution of previous marriage through divorce or death. Further analysis shows that out of the 42 married male PLWHA respondents, 10 (23.8%) were married to at least two wives. Out of these, 7(16.7%) and 3 (7.1%) had two and three wives respectively. Similarly, among the 79 married female PLWHA respondents, 17 (21.5%) were in their second or

Table 1. Some socio-demographic characteristics of PLWHA.

Variables	Frequency	Percentage
Religion		
Christianity	105	86.1
Islam	15	12.3
NR	2	1.6
Total	122	100
Ethnic group		
Idoma	75	61.5
Igala	10	8.2
Ibo	4	3.3
Yoruba	2	1.6
Tiv	5	4.1
Igede	1	0.8
NR	25	20.5
Total	122	100
Occupation		
Farmer	28	23
Civil servant	19	15.6
Trader/business	37	30.3
Students/apprentice	9	7.4
Housewife	4	3.3
Applicants	3	2.5
Retired civil servants	3	2.5
TSS (Treatment support specialist)	4	3.3
NR	15	12.3
Total	122	100
Marital status		
Married	61	50
Single	18	14.8
Widow(er)	21	17.2
Separated	3	2.5
Divorced	10	8.2
NR	9	7.4
Total	122	100
Educational level		
No formal education	16	13.1
Primary	31	25.4
Secondary	36	29.5
Tertiary	18	14.8
NR	21	17.2
Total	122	100

Source: PLWHA survey.

more marriages due to either divorce or death of former husbands. The implication of this is the tendency of their new spouses of these PLWHA to be infected if they were not previously.

This fear was expressed by all the informants from in depth interviews. The matron (head nurse) in charge of the Centre B outstation Health Clinic had complained bitterly that:

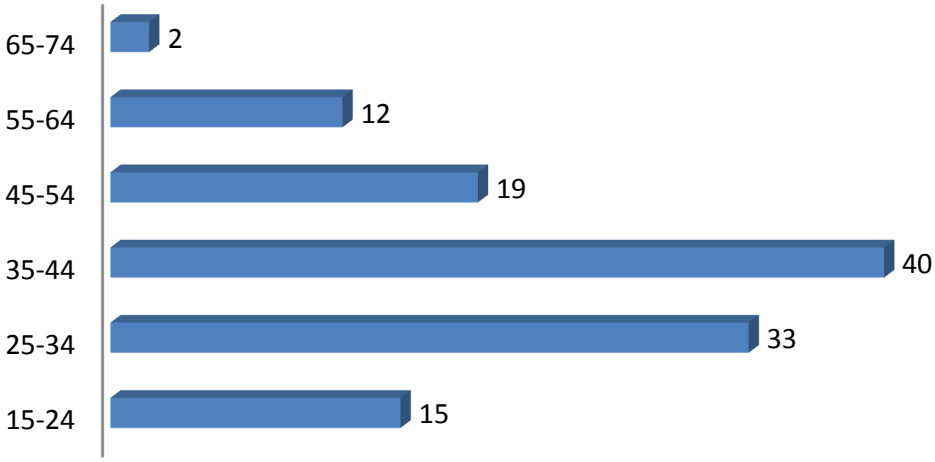

Figure 1. Age distribution of PLWHA (N=121; *****Mean age=38.3 years; ** Missing data=1). Source: PLWHA survey.

efforts at halting the spread of the HIV/AIDS in Idoma land had witnessed setbacks because PLWHA on treatment and looking healthy go back to the community and marry unsuspecting persons.

The tendency of some PLWHAs to deliberately infect others has been established in Idoma community. In his paper at the Association of Nurses in AIDS Care Conference held in USA, Anyebe (2012) stated how some PLWHAs attempted infecting others intentionally, including nurses caring for them.

Concerns and issues of marriage

Among the 49 unmarried, divorced or widowed PLWHA respondents, 22 (n=44.9%) expressed the desire to still marry. Marriage in the Idoma land focuses most on the desire to have children, implying that unless more enlightenment and strategies such as PMTCT are given, it will be a future disaster for the unborn generation.

However, 24 (49%) of the unmarried were unwilling to ever marry again for reasons ranging from claiming to be too old (12.5%), through seeing no necessity for husband (4.1%) to fear of transmitting the HIV to others (8.2%).

On other hand, most of the PLWHA (75.4%, n=92) also have children; majority (45.1%, n=55) have 1-4 children, 24.6% (30) 5 to 8 while 5.7% (7) have between 9 to 12 children.

Age distribution of PLWHA

As shown in Figure 1, it is indicated from this figure that majority 88 (72.7%) of PLWHA in this study were in the age group of 15 to 44 years (with a mean age of 38.3 years), implying that most of the PLWHA are within their most productive and reproductive years. Many other studies implicate this productive age group in HIV prevalence. Adekeye (2005) reported that adolescents and youths remain the major propellers and casualties of the pandemic. Gallangher (2000) had earlier reported that the HIV infection rate is highest in 19 to 35 years. According to him, this portends danger for population structure as the younger people will die, leaving behind orphans who are usually cared for by older ones who are themselves dependents. This situation has been viewed by Barnett and Blaikie (1991) as an 'impending disaster' with serious implications for developmental issues and agricultural production.

Gender distribution

Figure 2 shows the gender distribution of the PLWHA. It is indicated that the PLWHA accessing HIV services in the study area were predominantly females (64.8%, n=79), with males making 34.4% (42). The predominance of the female gender forming the majority of the respondents may be an indication that women are either more infected with HIV or more openly access HIV services or both.

This female:male ratio of affectation was corroborated by records of HIV screening at the two treatment centres as shown in Table 2. The table represents the gross data for the two treatment centres from 2002 to 2003, and 2006 to 2010. The table shows differential rates for the HIV sero-prevalence (positivity) in males and females. As shown, the overall prevalence rate of HIV infection in the study area is 20.2%. When compared along gender lines, females have a higher prevalence (24.5%) than males (14.3%). This is in addition to the antenatal prevalence

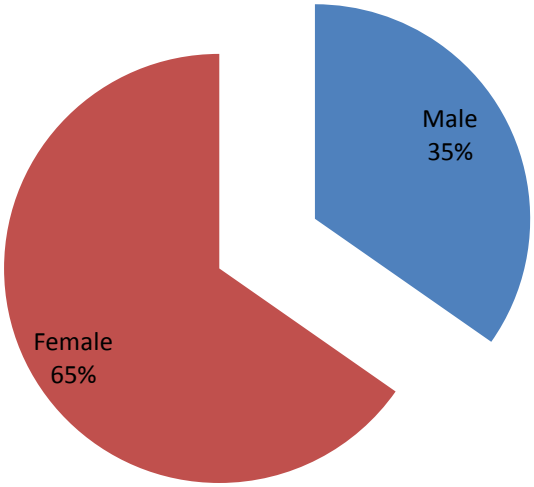

Figure 2. Gender distribution of PLWHA (N=121, NR=1).
Source: PLWHA survey.

Table 2. Gender distribution of HIV positive results in the study area.

Screening/Sex	Frequency		Total (%)
	Positive	Negative	
Male	2458 (14.3%) (30.0%)	14730 (85.7%) (45.5%)	17188 (100.0) (42.3%)
Female	5732 (24.5%) (70.0%)	17671(75.5%) (54.5%)	23403 (100.0) (57.7%)
Total	8190 (20.2%) (100.0%)	32401 (79.8%) (100.0%)	40591(100.0) (100.0%)
ANC prevalence	752 (7.1%)	9801(92.9%)	10553(100.0)

Source: Records from Centre A/IHVN/ICAP and Centre B.

Table 3. Hospital admissions for HIV/AIDS patients in a General Hospital.

	2002	2003	Total
Male	34 (38.6%)	42 (46.7%)	76 (42.7%)
Female	54 (61.4%)	48 (53.3%)	102 (57.3%)
Total	88 (100%	90 (100%)	178 (100.0)

Source: Medical Records at Centre A

rate which is exclusive for women.

Furthermore, the gender differential can also be shown by the rate of hospital admission (Table 3) and death records of PLWHA extracted from one of the hospitals. Data on the admission rate for HIV/AIDS patients at the General Hospital for 2002 and 2003 showed that more females, 61.4% in 2002 and 53.3% in 2003 were admitted. The male prevalence rate for 2002 and 2003 was 12% while that of female was 17.6%.

From the Patient Admission Register (not shown in the Table), data in 2002 also showed ten (0.9%) HIV-related deaths (5 males, 4 females; male: female ration 3:2). In

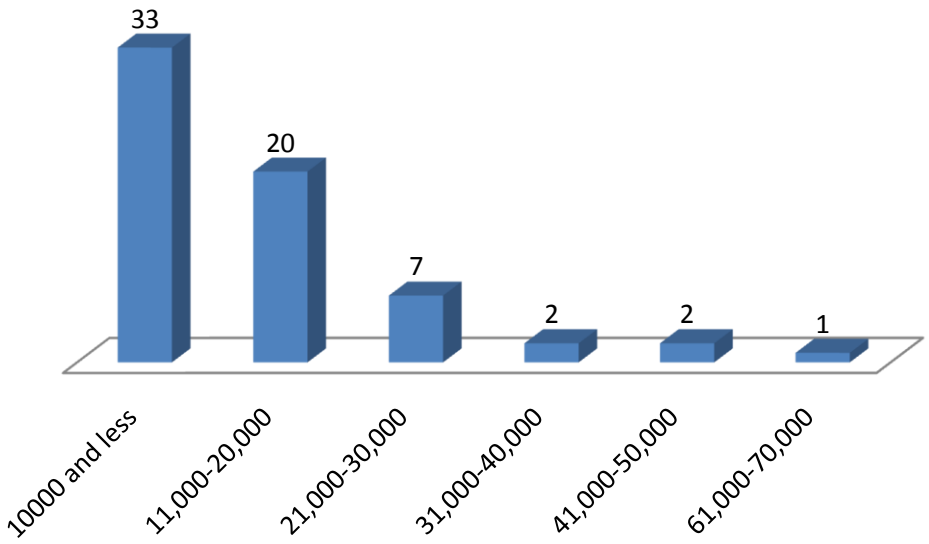

Figure 3. Monthly income of PLWHA (N=65; Mean income N13, 807.67).
Source: PLWHA survey.

2003, there were twenty-five (27.8%) HIV-related deaths, including 11 males, 14 females, ration 0:8:1. Out of 24 admitted in January and February 2004, eight (8) of them died (2 males, 6 females), representing a death rate of 33.3% with a male: female ration of 1:3. Thus, in general, death rate for HIV-AIDS between 2002 and 2004 ranged from 0.9% in 2002 to 33.3% in 2004.

The records from the two centres support this differential gender distribution: most people living with HIV/AIDS are women. Various reasons may be given for this finding. One reason usually associated with these differential rates is the socio-cultural and economic factors where women have been frequently seen as placed in a disadvantaged socio-economic status (Ajuwon and Sokunbi, 1996; Gilks, 1998). Gilks (1998) had asserted that women are more infected with the HIV because they are more vulnerable than men both in terms of exposure and impact, because of the limited power of women in many societies to demand and practice safer sex. The threat of domestic violence on disclosure of HIV status, the burden of pregnancy and child bearing, poverty, and poor access to care and supports are other socio-economic explanations for higher prevalence rates in women (Gilks, 1998). In his contribution to the propagation of HIV in the society, especially in Africa, Hellandendu (2001) postulated the dominance-subservience argument, which he also linked to differential economic opportunities, often biased against females, and thus predispose them to commercial sex work in order to earn a living. This explanation appears apt for the situation in Idoma land with limited economic opportunities.

Many girls in Idoma land were commercial sex workers outside the State, as reported by key informants. This must have necessitated what a community leader said that: “the traditional/community leadership has place sanctions on certain practices that are believed to propagate HIV”, such as the sanctions on the hitherto thriving sex occupation (that is, ‘prostitution’) by their young girls and unenforced rules on HIV screening before marriage. Religious institutions have been involved in this as well. Oluwabamide and Umoh (2011) had indicated the vital role the religious institutions play in the overall health care delivery system in the community. Their recommendations have serious implications for HIV/AIDS control.

In a related sex differential finding, it is found in this study that AIDS-related deaths are higher in females, while antenatal prevalence remains unique to the feminine gender. In his own view, Isuigo-Abanihe (2005) believes that the basic explanation why women are disproportionately affected by HIV/AIDS is the status of women in the patriarchal society, where women are forced to take greater risks in their sexual lives. The Idoma-speaking people of Benue State fit into that social arrangement.

Income profile of PLWHA

The income profile of PLWHA (Figure 3) reveals striking low earnings, with a mean monthly income of N13, 807.67 (about U$ 70). As shown in Figure 3, out of the 65 PLWHA who reported their monthly incomes, 33 (27.0%) of them earned N10, 000.00 or less per month; only 3 (2.4%) of the respondents earned between N41, 000.00

Table 4. Positions of the PLWHA in the nuclear family.

Position in family	Frequency	Percentage
First	8	53.3
Second	2	13.3
Third	2	13.3
Fourth	1	6.7
Seventh	1	6.7
Eighth	1	6.7
Total	15	100

Source: PABA survey

and N70, 000.00 in a month. Many of them reported having no monthly income.

The findings on the socio-demographic attributes of PLWHA in Idomaland from narrations from most informants from the in-depth interviews from both the community and health care institutions support the quantitative data. They said that women and the poor constitute the bulk of attendants at the HIV clinics. For example, the Monitoring and Evaluation (M&E) Officer in charge of one of the Treatment centres summarized the socio-demographic profile of PLWHA who patronized the centre thus:

The group of patients (HIV) seen here are people of between 20 and 40 years; the females are more and it's like it affects the poor more than the rich people. Though, most of the rich people do not come here. They access their drugs somewhere else, so we have more poor people around here. We also have more singles than married people although couples also come here.

However, contrary to the PLWHA socio-demographic attributes obtained from the survey questionnaire from the PLWHA, many informants interviewed believe that unmarried females are more affected as implied in the narrative above.

Positions of the PLWHA in the nuclear family

To provide additional data to further determine the socio-demographic attributes of PLWHA, 25 relatives of PLWHA that is people affected by AIDS – PABA) were asked to state the position of their relatives who were HIV positive in their nuclear. Majority (53.3%) of the PLWHA was reported to be first children of their respective nuclear families (Table 4). Explanations for this finding could not be clearly linked to any previous study.

However, the socio-cultural and political structure of a typical Idoma community is one that usually places an enormous care burden on first born children of a family. He/she is expected to fend for both the parents and the younger ones, and often the extended family structure. The high prevalence rate among the first born children most of whom are coincidently are females appear suggest economic pressure as a precipitating factor for risky behaviours as means of economic survival (possible transactional sex). The fact that in Idoma land first born children often take up the responsibility for the young siblings is a possible economic explanation for the high prevalence among the first born who are mostly female (Figure 2). Pointers to this assertion were made by other authors (Hilhorst et al., 2004.)

Conclusion

The socio-demographic attributes of Idoma PLWHA reveal that young, married females of low income and educational groups are most infected by HIV/AIDS; the most affected being those within the age range of 25 to 44 years. This age bracket constitutes the productive stratum of the society, thus any neglect of the control of the HIV/AIDS situation in Idoma land may portend disaster, a fear expressed by Barnett and Blaikie (1991) and Mlama (2002). In addition, the fact that separated, divorced, widowed or never married PLWHA still marry, remarry or plan to marry unsuspecting people, without the necessary precautionary measures such as pre-marital HIV screening might facilitate the spread of HIV and again compound the already precarious HIV/AIDS situation in Idoma land, a resource-challenged society.

RECOMMENDATIONS

Based on these findings, it is recommended that mass educational measures like AIDS education focusing on women, youths and the community at large be put in place to bring about behaviour change. Such HIV/AIDS mass education should be in Idoma language based on principles of Behaviour Change Communication (BCC). The religious and Idoma traditional institutions (Oluwabamide and Umoh, 2011) should be involved to help design culture-appropriate methods. Governmental and non-governmental agencies should help sponsor such educational efforts.

Similarly, measures to empower women and young people economically and socially in terms of vocational opportunities should be put in place. This can be achieved through community-oriented programmes such as *Age-group Support Clubs*. Age groups are functional units in traditional Idoma society and most community responsibilities and controls are usually implemented through age groups. This can further be supported by well coordinated government-assisted initiatives such as the micro-credits, which can again be disbursed through age-groups and/or organized cooperative societies where these exist. Well organized cooperative societies in the communities can attract inputs (such as money, technical support, implements) from non-governmental and private

organizations. The local, state and federal governments in conjunction with community/group leaders can work out the modalities for the effective negotiation and implementation of such initiatives to combat poverty. International organizations can also voluntarily link up with relevant local authorities to intervene.

In addition, philanthropists especially among the wealthy Idoma people should identify areas of need in Idoma land so as to put in place appropriate measures to improve the general socio-economic status of Idoma people, including mass literacy. All levels of governments should also see this as an urgent area of need. This has been done in some places.

Manageable family sizes for Idoma families are also advocated to take off undue socio-economic pressure from older siblings. High number of children for whom parents cannot adequately cater for has been responsible for the older siblings' economic pressure. This has been attributed to some risky economic undertakings like unprotected commercial sex especially by young female siblings. Manageable family sizes values in Idoma land might reduce the burden.

The Idoma people equally need a formalized system of community check system, such as mandatory pre-marital HIV confidential counselling and testing before all traditional Idoma marriages are conducted and community sanctions on non-compliance, to protect unsuspecting community members from HIV infection. Like in Uganda's rural communities, leaders and concerned Idoma sons and daughters should, collectively and individually, rise up to the challenges of the threat of HIV/AIDS in the land.

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Appendix A: ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome
CSW - Clandestine sex workers
FGDs - Focus Group Discussions
FMoH - Federal Ministry of Health (Nigeria)
HIV - Human immune virus
ICD - Idoma Community Development
IDIs - Indepth Interviews
IHVN - Institute of Human Virology
LGA - Local Government Area
M&EO - Monitoring and Evaluation Officer
MSM - Men to men sex
NGO - Non-governmental Organisation
PABA - People affected by AIDS (relatives of PLWHA)
PLWHA - People living with HIV/AIDS
SPSS - Statistical Package for Social Sciences
STIs - Sexually Transmitted Infections
WHO - World Health Organisation