

AN ASSESSMENT OF THE SOCIO - ECONOMIC IMPACT OF HIV/AIDS ON SELECTED HOUSEHOLDS IN MAIDUGURI METROPOLIS

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ABSTRACT

This paper assesses the socio-economic impact of HIV/AIDS on some selected households in Maiduguri Metropolis, Borno State. The work utilizes both primary and secondary data. Descriptive statistical tools such as tables and percentages were employed to present the data obtained. The study revealed that the HIV/AIDS pandemic in the study area is affecting all dimensions of social and economic life. The prevalence rates of HIV/AIDS and the number of adult deaths due to its scourge has resulted into high medical expenses, increasing labour hour losses, increasing number of orphans and vulnerable children, as well as rising levels of divorce and separation among couples. Based on the findings of the study, the study suggests that massive awareness campaign on HIV/AIDS be vigorously pursued by the Government and Non-Governmental agencies as this will greatly help in reducing vulnerability among the populace.

INTRODUCTION

The macroeconomic effects of Human Immune Virus/Acquire Immune Deficiency Syndrome (HIV/AIDS) in Sub-Sahara Africa are substantial, and policies for dealing with them may be controversial. HIV/AIDS is responsible for over one million death a year in the world, of which a greater percentage are from the developing world especially sub-Saharan Africa. HIV/AIDS has been a household name in all parts of Africa; it has gone a long way in reducing the number of the population in the continent especially the active workers whose ages range from 25-45. Each day more than 10,000 people in sub-Saharan Africa are handed with what is almost surely death sentence and all of them will likely be dead in the next 10 years (Watson. 2001).

The burden of HIV/AIDS is falling heavily upon the developing world especially in the Sub-Saharan Africa. In 1999 United Nations Agency for International Development (UNAID) estimated that 70% of all HIV/AIDS infections had occurred in sub-Saharan Africa although it is home to only 10% of the world's population. However, not only will the impact of an adult AIDS death drastically reduce labour, but illness before death and the time spent by members of the family caring for such person reduce productivity. For instance, resources used to purchase inputs may be diverted for such expenses such as medical treatment and later funeral cost, and reduced inputs will mean reductions in household resources. The productivity, capacity, purchasing power and per-capita income, food availability of household are likely to reduce when adults die. Disruption of family structure and malnutrition will spread resources more thinly (Watson, 2001).

HIV/AIDS decrease income and productivity by removing from the labour force not only the sick person, but also other members of the household who must care for the patient. According to a report from the Joint United Nations Programme on HIV/AIDS, families in Cote d'Ivoire, Tanzania and Nigeria who were coping with HIV/AIDS experience a fall in income of 40 to 60 percent. Loss of income and Agricultural labour in turn causes a decrease in household access to nutritious food. Nigeria, and Maiduguri in particular, is in the grip of a growing HIV/AIDS epidemic with serious Socio-Economic effects, particularly on poor households.

The people of Maiduguri seldom acknowledge that HIV/AIDS is a problem with Socioeconomic implications. This is evident by the low level of HIV/AIDS knowledge among the majority of the Borno State populace (Gwoza, 2001). This paper is an attempt to assess the socio-economic effect of HIV/AIDS among the poor families in Maiduguri Metropolitan Council.

The primary objective of this paper is to assess socio-economic impact of HIV/AIDS on selected households in Maiduguri Metropolis. Specific objectives of this study are to:

- (a) Assess the total monetary lost to HIV/AIDS for the selected families in the studied area.
- (b) Analyse the proportion of household income spent on HIV/AIDS pandemics in Maiduguri.
- (c) Assess the magnitude of household labour hour lost to HIV/AIDS pandemic in Maiduguri.

PERSPECTIVES ON THE IMPACT OF HIV/AIDS

A study carried out by UNAIDS (2002) reveal that an estimated 20 million Africans have died since the start of the HIV/AIDS epidemic. A further 29.4 million are presently living with the virus. It is in Africa that the grip of HIV/AIDS has been far, the deadliest in the world. It was discovered that almost one in every ten adults in sub-Saharan African is HIV/AIDS positive (UNESCO, 2002). According to Barnett and Whiteside, (2002) they postulated that HIV/AIDS leads to financial resource impoverishment. From the psychological and medical perspectives women are at risk of getting infected, abandoned or abused at the hands of the partners when HIV/AIDS strike, (Barnett and Whiteside, 2002). Gross analysis conducted by the World Bank suggests that the region of Southern Africa is losing an estimated 0.1 to 0.7 percent per capita growth per year as a direct result of HIV/AIDS and that by the year 2010, it may have reduced aggregate output between 15 to 20 percent (World Bank, 2002).

The economic aspect of the AIDS epidemic gets the attention of policy makers, planners and politicians because it may cause difficulties and in particular, might result in a slowing of economic growth. Economists agree that HIV/AIDS may affect economic growth through two factors. The first is the illness and death of productive members, the second is through the diversion of resources from savings (and eventually investment) to care.

The way in which this might occur is ably described by Cohen, 1993 and over, 1992. The next step (in the absence of hard evidence that AIDS has an economic impact) is to develop a model to show the impact the epidemic might have. This has been done for groups of countries and for individual countries. Early indications are that the process is fraught with difficulty. Economists find it hard to forecast economic trends and combining them with two other unknowns (the epidemic trend and its inter-relationship with the economy) simply compound the uncertainty.

The result of the cross-country analysis provides little support for the widespread claim that the AIDS epidemic will slow the growth rate of income per capital. Although the epidemic is already quite advanced in a number of countries there is no evidence that the economics of those countries grew at a significantly slower pace between 1980 and the early 1990s than those of other countries in which change in cumulative prevalence of AIDS was lower (Bloom and Mahal, 1995).

Resources use (domestic consumption, government expenditures, exports and investment) cannot exceed available resources (domestic

production, spending of accumulated wealth through capital depreciation, foreign resources other cash flows such as from lenders, and so on). Foreign borrowings and sales of national assets may be used as ways of additional finance, but they also affect long-term growth. As a result, government, producers and households may shift spending patterns over time to cope with the costs of AIDS, which may lead to a greater burden of the costs being shifted away from formal systems. With poor monitoring of economic conditions at informal sectors and household level, these costs may seem to disappear at least from the data bases of the formal sector and the macro-economy.

Macro Economic Impact

The macro-economic factors influencing susceptibility are fairly simple and appear intuitively to be borne out of the epidemic around the world. Poor have or will have worse epidemics than richer ones. The health status in poorer countries is generally worse than in wealthy countries, where a country is poor and income unevenly distributed, then the poor will be even poorer and thus more susceptible to diseases; while richer men may, initially at least, purchase more sex because they can afford it and it is more readily available, if women cannot find employment, the sales of sex becomes vital survival mechanism for many. Changes in GDP and GDP per capita preliminary data based on 51 countries indicated that HIV/AIDS has, so far only a small statistically significant negative impact on these macro-economic indicators. Specific countries in the region, for which the epidemics impact has been modeled, show that HIV will probably reduce the rate of economic growth over a period of 20 years, this may be significant (up to 25% lower than it would otherwise have been). (Bonnell, 2000).

Impact On Labour

If the epidemic is to have an effect on the national economy, it must have an adverse effect on the productive labour force. The effect, however, will not be uniform as it depends on who is affected and how easily they can be replaced. Little information is available on the differences of scale of the epidemic by Socio-economic division. In Southern Africa, there is generally a surplus of unskilled labour. If the epidemic is primarily located among the unskilled and easily replaceable members of the workforce, then it will have less of an impact than if it is located among the highly skilled, hard to replace workers.

It should be remembered that the majority of workers will not die in service; generally, they will have been medically discharged or left

voluntarily to die. Of great concern is the increase in sickness. Once people's immune systems begin to break down, they will experience episode of sickness that will increase in duration and frequency until they are totally incapacitated. In general the disease will run its course in one to two years, but this will depend on the nutritional and health status of the person plus the level prophylactic treatment available.

In developing models to look at economic impacts, economists have to make assumptions about the location of the epidemic or different scenarios. For the most part models look at the impact of mortality. In some countries mortality, in such country, morbidity may be as important, especially in government service, which has general sick leave benefits. For example, in Swaziland, government service employees may have six months of sick leave on full pay and six months on half pay (Whiteside and Wood, 1994). In other countries, this may stretch even longer as employees cannot be dismissed until they have been boarded (that is medical board has been covered by the government to confirm that a person is no longer capable of working). During the period of illness a person will not be working but will be paid and, even more important his or her past cannot be filled.

The effect of the epidemic on the work place will occur because employees and their families will experience an increase in illness and death, and this will be in addition to current level of morbidity. The extent to which company is affected will be determined by the number of people who fall into ill and die, their role in the company the impact on productivity and the increase in direct and indirect costs.

Existing studies show that in Tanzania, the estimated size of labour will shrink by 2010, because of AIDS, and the mean age of the worker will fall from 32 to 28 due to a shift to younger and less experienced work force (ILO EAMAT, 1995). Training costs to replace skilled workers (direct training and lower productivity until the skills base is replaced) in Zimbabwe were estimated in 1993 at US\$ 2500 per worker. Average of the number of people with AIDS in the formal sector intimated that training cost would increase from US\$ 1 Million in 1995 to US\$ 5 million in 2000. (Cuddington, 1993).

Impact On Savings

The second area is the impact on savings and hence investment. The argument is simple: individuals who fall ill divert their savings into consumption in order to maintain themselves and their dependents. They will also liquidate their existing savings and possibly their fixed assets. In some

countries, the instruments for mobilizing savings include pension schemes and life insurance. The life insurance industry is aware of the implication of the HIV epidemic for macro-economic and government revenues.

There is little empirical data on how households finance AIDS in relation to savings behavior. There is an area needing further research. Household survival strategies might include selling land and cattle to finance medical care, or reduce consumption of other household members. But anticipatory behaviour may in fact increase savings. For example, the Kayera study in Tanzania found that new savings, credit and mutual aid society have developed, and evidence suggests that households are insuring themselves against likely further death. Further information on the relative roles of formal and traditional sources of support is needed. (Whiteside, 1988). Sectors and units or organizations in sectors (enterprise, production units, and organizations) are areas where the impact is likely to be considerable.

In economic terms, sector is defined as a homogeneous group of productive economic activities@ the most common set of sectors are found in national data. For example, some Southern African governments list sectors of origin such as agriculture (which may be subdivided into subsistence, individual term forms, and livestock and other), forestry and mining amongst others for Gross Domestic Product. Clearly, a sector@ as defined in economic terms are too broad for useful analysis of impact of the HIV/AIDS or planning of interventions. Sectoral analysis would only be useful if the sectors are clearly defined, further disaggregated and differentiated one from the other. In this context it is useful to define sectors or sub-sectors as activities that use labour in similar ways to produce similar outputs.@"

No assessment of the sectoral impact in the region has been made. A number of studies of single or group enterprises have been made, however. For example, the World Health Organizations Global Programme on AIDS (GPA) commissioned a series of AIDS Briefs for Sectoral Planners and Managers@. The briefs give a general analysis of the possible impact on that particular sector and present a useful checklist of points and issues that need to be looked at in order to monitor the impact of HIV/AIDS (see Barnett et al 19996). Some key areas have not been included in these sectoral briefs, e.g. transport, finance, the civil service and fishing.

Impact On Enterprises

Available data on the impact of HIV/AIDS on private sector

companies are limited. However, the major problems with finding evidence for the impact of HIV/AIDS are:

- i. Most countries are still experiencing an expansion of the HIV epidemic rather than the AIDS epidemic.
- ii. Countries further ahead in the epidemic are generally poor and agriculturally based.
- iii., It will make time for the impact to be tested and for the companies to adopt policies to reduce the negative impact of the scourge. There is consensus that AIDS will have an impact because;
- iv. Productivity is reduced as AWorkers are ill and absent from work or performing below expected productivity. Productivity will suffer when workers leave the company and are replaced with less experienced people.
- v. Costs will rise. These include benefits such as life insurance, medical care, death benefits as well as cost associated with replacing workers such as recruitment and training. (Whiteside, 1995).

The situation in Africa is complicated by the economic structural adjustments that many countries are undergoing. The programme has lead to companies downsizing by retrenching and in some cases closing down.

Impact On Households

Changes in per capita income, linked to economic recession, and increase in the cost of agriculture inputs and climatic instability are now intertwined with the impact of HIV/AIDS. A number of studies as carried out by Whiteside (1996) and Hanson (1992) on rural communities reveal that robust farming systems are likely to withstand the worst ravages of HIV/AIDS. In Tanzania regions like Kagera and Rukwa which are among the most affected by HIV/AIDS are predicted to be resilient and food insecurity negligible, other less robust areas with lower HIV prevalence may be most affected (Barnett, 1994).

The impact on the household has three phases viz. (i) the illness (ii) the death, and (iii) the long-term consequences. In illness and death phases, the costs of caretaking increases, the long- term cost may arise as widows lose rights to property (Whiteside and Fitzsiomns, 1992).

The impact of HIV/AIDS at the household level is multi-faceted because a number of behavioural responses may take effect when a family gets ill. For example, the family members, productive labour is often re-allocated from producing income outside the home to caretaking/maintaining the family land. Death of the adult worker may lead to reduced remittance,

reduced access to land, housing, assets, and farm, inputs, reduced family labour and schooling, and shifts from cash to subsistence crops. The three principal areas of household impact are:

- i. Increased medical care, special diet and transport expenditure.
- ii. Decreased investments in productive activities, education and savings.
- iii. Decreased revenue from loss (approximately 75% of productive life years lost due to early death from AIDS).

However, one might analyse and categorize the impact. Clearly this is a highly specific effect, one that is contingent on who has AIDS and the family structure (size, age of children etc). Martin and Giovanna, (1999). Whiteside and Fitzsimons (1992) distinguish between AIDS- affected household (cash contributor dies) and AIDS-affiliated household (non-cash paying household member with HIV dies). Loss of income and diversion of productive labour time, diversion of cash to medical expenses and diversion of food reserves to funeral cost, withdrawal of children from school, increase orphans and the changes in the producer/consumer ratio produce a burden that may push household from >acute/seasonal poverty to chronic poverty and food insecurity. The coping capacity depends on household resources and community support structures.

Within households, specific groups of people may be highly vulnerable to the impact of AIDS. Women take on double burden of production and caretaking maintaining the family land (Ankrah, 1999). The additional burden of AIDS has led to women forming groups around these issues, for instance, the society for women and AIDS in Africa (SWAA) has chapters in the specific needs of women and children in respect to AIDS (Oppong, 1994).

The impact of HI V/AIDS on households is poorly explored, especially in terms of economic and social aspects relating to ways households produced and earn incomes (both farming and non farming) and contributed to the production of labour and to social welfare.

In addition to the effects already noted, the impact on women also include loss of their male spouses work benefits and security, increased childcare responsibilities, increased trading in sexual activities to secure income for household needs and increased vulnerability to sexual harassment and exploitation at and beyond the workplace (ILO EAMAT, 1995).

The impact of HI V/AIDS related illness or death will not only affect labour inputs to Afarm@ production, but will also affect the balance of labour available to the household and the farm which should be considered as one

entity. Foster (1995) noted that in Monze District in the Zambia, the burden of AIDS care falls on women, leading to potential labour shortage and a negative impact on productivity. In 1992, the combined impact of drought and AIDS is noted to have negatively affected crop output with chronic labour shortage problems making recovering from drought more difficult.

A BRIEF ON THE STUDY AREA

Maiduguri, the capital city of Borno State, is located on latitude 115° N and longitude 135° E. The city stands on some 230 metres above sea level on relative undulating plains and occupies an area of about 50, 778km²

The city is situated in a semi-arid climatic zone. In this zone, there are two seasons, the dry and the wet seasons. The wet season starts in May/June and ends in September, while the dry season commences around October and ends in April. The heaviest rainfall and the highest number of rainy days experienced in the area is mainly the conventional type with short showers. Rainfall concentration is usually in the month of July, August and September. The rainfall and transpiration (evapo-transpiration) is in the month of July, August and September, which can really be considered as humid because at this time precipitation is greater than evaporation. Both diurnal and nocturnal ranges of temperature are high in the area. The coldest months are December, January and February. During this period, temperature ranges from 29.40 C to 350 C. Around April, May and June, there use to be a sudden rise in temperature during the day and high terrestrial drops abruptly during the night, resulting in high daily temperature ranges, sometimes, a temperature of about 400 C can be observed.

Maiduguri falls within the savannah woodland zone which is characterized by a relatively light trees growth with a more or less continuous cover of grass. It is specifically located in the Sudan savannah belt.

The principal ethnic groups in Maiduguri Metropolitan Council are Kanuri, Hausa, Shuwa, Bura, Marghi and others. The Kanuri account for only about half the total population of the city and there is the possibility this proposition will decline as great number of other ethnic groups now migrate into Maiduguri.

The Kanuri have concentration in Maiduguri village, Limanti, Fezzan, Shehuri North and Shehuri South. The city has a population of about 613,644 people according to 2006 population census. As one of the oldest cities, the main and most popular occupation of the indigene of Maiduguri Metropolitan Council are farming and trading.

METHODOLOGY

Data were collected from primary and secondary sources. The primary data were collected through questionnaire administration with some medical personnel of the University of Maiduguri Teaching Hospital (UMTH), as well as the selected households in the study area. The secondary data were sourced through consultation of published materials from relevant sources such as Federal Ministry of Health, UMTH, State Specialist Hospital, Borno Medical Clinic, Nakowa Specialist Hospital, BOSACA and Society for Family Health.

Thirty households were purposively sampled for the study in Maiduguri, Borno state. Available data have it that the population of the people living with the HIV/AIDS in the study area is enormous. A reasonable selected number of the HIV/AIDS infected persons in the households are purposively sampled. As a result of stigmatization, it is difficult to identify most HIV/AIDS patients. The study therefore purposively use records from relevant health institutions in the study area. To present the data collected, descriptive method was employed where tables and percentages were used to present the data obtained.

ANALYSIS AND DISCUSSION

The socio-economic effects of HIV/AIDS on selected households in Maiduguri Metropolis such as cost of hospitalization, loss of labour hours, impact on orphans, and the social problems associated with HIV/AIDS are highlighted.

COST OF HOSPITALIZATION

Table 1 shows the extent of loss due to cost of hospitalization for the selected thirty (30) households in Maiduguri Metropolis. On a closer examination there are one hundred and sixty (160) members in the selected households. The table reveals that 50 members of the selected household are infected with the deadly virus. In addition, the 30 households selected earned a pulled income of ₦ 585, 000 and incurred a total of ₦192, 000 on hospital expenses (HE). The highest health expenditure as a percentage of income is incurred by household group 21-25 (29.05%). This group constitute largely of small scale business operators who realize higher income relative to the other household groups. While the least is incurred by household group 6- 10 (12.49%).

TABLE 1: THE EXTENT OF LOSS DUE TO COST OF HOSPITALIZATION

The financial cost of HI V/AIDS is enormous. It may be tens of millions of naira annually.

Household in Group	Number of Household Member Infected	Pulled Monthly Income	Monthly Hospitalization Expense	Health Expenditure (HE) as a % Monthly Income
1-5	09	79,000	30,000	13.51%
6-10	08	73,000	26,000	12.49%
11-15	08	96,000	30,000	16.41%
16-20	07	87,000	26,000	14.87%
21-25	10	170,000	51,000	29.05%
26-30	08	80,000	28,000	13.67%
TOTAL	50	585,000	192,000	99.45%

Source: Field survey, 2008.

Loss Of Labour hours

Table 2 shows the labour hour lost to HIV/AIDS due to nursing and hospital attendance for the selected 30 families within Maiduguri Metropolis. A critical examination of Table 2 shows that the pulled household weekly labour hours loss to HIV/AIDS in total is 1, 064 while the corresponding total monthly estimated income lost is N 213, 781. Furthermore, Table 2 shows that the weekly labour hours lost in percentage terms varies from one household to another as shown in column 4 of the table. The highest labour hours lost recorded in percentage terms falls in household group 21-25 constituting (18.5%) while the least on record is in household group 1-5

constituting (15.7%).

TABLE 2: LABOUR HOURS LOST TO HIV/AIDS DUE TO NURSING AND HOSPITAL ATTENDANCE

The table 2 shows the labour hour spent in taking care of the infected.

Household in group	Household Weekly labour hours	Household weekly labour hours loss to HI V/AIDS	Labour hours percentage lost	Estimated Income lost to nursing and HA (monthly)
1-5	600	168	15.7%	32,623
6-10	600	178	16.7%	2,145
11-15	600	173	16.2%	40,244
16-20	600	173	16.2%	36,666
21-25	710	197	18.5%	66,650
26-30	620	175	16.4%	35,453
TOTAL	3,750	1,064	99.7%	213,781

SOURCE: Field survey, 2008.

Consolidated Monetary Cost Of HI V/AIDS

The consolidated loss to HIV/AIDS in monetary terms is given in Table 3. In sum, the 30 families under study lost ₦423, 881 per month to HIV/AIDS in 2008, as shown below

TABLE 3: Total Monthly Monetary Lost To HIV/AIDS (2008) For 30 Families In Maiduguri, Nigeria..

Household in group	Monthly hospitalization expense	Income lost in ₦	Total
1-5	30,000	32,123	62,123
6-10	26,000	31,745	57,745
11-15	30,000	39,744	69,944
16-20	26,000	36,166	62,466
21-25	51,00	57,580	109,180
26-30	28,000	34,423	62,423
TOTAL	191,000	231,781	423,881

Source: Field survey, 2008.

Tables 3 depict monetary loss to HIV/AIDS for the year, 2008, on a monthly basis. The total monetary loss stands at N 423, 881 being the sum of monthly hospital expenses incurred by all the household groups. In addition, total monthly monetary loss differs from one household to another. Column 4 of Table 3 shows that the highest monthly monetary loss recorded is ₦109, 180 for household group 21-25 while the least is ₦62, 123 for household group 1-5.

HI V/AIDS Impact On Orphans And Vulnerable Children (Ovc)

One impact of particular interest in that of orphan and vulnerable children: since most orphans had to drop out of school because their labour is needed at home or because fees and uniform can no longer be afforded once the bread winners die. Today there are millions of children orphaned by AIDS, and the number is growing, and will continue to grow as long as the number of the AIDS death continues to rise.

TABLE 4: Number of orphan and vulnerable children

Household in group	No. of Orphans in Selected Household	Number of House Members Enrolled for Anti-Retroviral Therapy	Number of Members Currently Receiving ART drugs.
1-5	04	02	30,000
6-10	03	02	40,000
11-15	03	02	40,600
16-20	02	01	20,300
21-25	05	03	25,400
26-30	03	01	18,300
TOTAL	20	11	174,600

Source: Field survey, 2008.

Table 4 shows that there are 20 orphans in the 30 selected households under study out of which 11 are vulnerable to HIV/AIDS and a whopping sum of ₦174, 600 is lost to acquiring ART drugs. This scourge has caused many drop out from schools due to ill health and stigmatization. It is worthy of note here that it is very difficult to cope with HIV/AIDS because once one is infected and it is fully-blown, one becomes weak and hence finds it difficult to work. It makes many infected people to be jobless due to their inability to cope with work, especially hard work.

TABLE 5: Number of people living with HIV/AIDS

Household in Group	Number of Household Member Infected	Number of House Member Enrolled for ART	Number of Household Members Currently Receiving ART Drugs
1-5	09	06	4
6-10	08	05	3
11-15	08	04	2
16-20	07	06	3
21-25	10	08	4
26-30	08	04	2
TOTAL	50	33	18

SOURCE: Field survey, 2008.

Table 5 shows the total number of people infected with HIV/AIDS among the 30 selected households within Maiduguri Metropolis. Fifty people are living with HIV/AIDS as shown in column 2 of Table 5, while 33 people are being registered for anti-retroviral therapy (ART). While column 4 of the Table 5 shows a total of 18 people already receiving anti-retroviral therapy in the selected household under study.

TABLE 6: SOCIAL CONSEQUENCES OF HIV/AIDS AT THE

FAMILY

Household in group	Number of children in the household	Dropped out of school due to finance	Number of Divorce /separation	Household Member Migrated to other Area as a result of HIV/AIDS INFECTION by a family member.
1-5	21	07	02	08
6-10	19	05	03	09
11-15	22	07	02	08
16-20	16	04	01	05
21-25	20	03	01	06
26-30	25	04	02	08
TOTAL	123	30	11	44

SOURCE: Field survey, 2008.

Table 6 reveals that of the 123 children in the selected households, 30 dropped out of school due to financial problem caused by the scourge of HIV/AIDS, eleven (11) families out of the total of thirty (30) families experienced divorce/separation due to spouse infection and inability to cope with hard times that result from HI V/AIDS infections.

In summary, Table 6 shows that the number of household members on migration varies from one household group to another. Column 5 of Table 6 indicates that the highest number of migration recorded falls in the household group 6-10 where 9 family members migrated to other areas as a result of infection of some family members by HIV/AIDS. And the least number of family members that migrate to other areas is within the family group 16-20 where 5 family members migrated.

CONCLUSION

This paper assesses the socio-economic effect of HIV/AIDS for 30 households in Maiduguri, Borno State. The study supports empirical assertions that HIV/AIDS is of high prevalence in Sub-Saharan Africa. The data on prevalence depicts an increasing trend and this is expected to continue if nothing is done.

The implication is that Labour force declines as well as agricultural productivity. Also the social problems such as orphans, widows, school drop outs and so on attached to this pandemic are alarming.

It is however, significant for individual, households, corporate bodies, NGO=s and the government to expedite collective actions in organising advocacy and awareness campaign on HIV/AIDS in the study area, especially among poor households.

The following recommendations are proffered. It is suggested that a programme that will ameliorate if not completely eliminate the scourge, should be vigorously pursued. Government should design and implement effective and efficient policies as well as measures and targets aimed at combating the scourge on the economy.

All sectors of the society should be involved in fighting the menace of HIV/AIDS. This includes the public sector at federal, state and local government levels, private sector community based organizations, NGO=s, donor agencies, religious, traditional and youth organizations. The government and the people should therefore be committed to

- i. Creation of awareness by embarking on HP//AIDS awareness campaign as this will help in reducing vulnerability among the populace.
- ii. Promote positive behavioural changes among people that will help to stem human toll of the epidemic.
- iii. Provision of treatment, care and support to people living with HP//AIDS.
- iv. Protect the rights of all individuals infected by the HIV/AIDS scourge.

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