

**A SURVEY OF THE IMPACT OF HIV/AIDS PREVALENCE, MORBIDITY AND MORTALITY PATTERN ON ORPHAN AND VULNERABLE CHILDREN AMONG THE IDOMA-SPEAKING PEOPLE OF BENUE STATE, NORTH-CENTRAL NIGERIA**

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**Abstract**

**Background:** HIV/AIDS is responsible for over 1.6million deaths in Nigeria over the last decade. Idoma-speaking people of Benue State of Nigeria, as one of the most affected communities in Africa, also have one of the highest HIV/AIDS-related mortality. **Objective:** To investigate the prevalence HIV/AIDS on households, HIV/AIDS-related morbidity and mortality, and their impact on orphans and vulnerable children among the Idoma-speaking communities of Benue State. **Methodology:** In-depth interviews were conducted on nine health workers and nine community leaders; focused group discussions on 11 PLWHAs; and questionnaires were administered on 122 PLWHA and 25 relatives/guardians of PLWHAs from two HIV/AIDS treatment centres; and 158 adults from selected households in six communities from three Local Government Areas in Idoma land. Hospital records of positive HIV screening results were also retrospectively studied. **Results:** The findings showed that 57% of the households surveyed either had living HIV positive persons or lost relations from HIV/AIDS; 33.3% have lost at least a household member from AIDS in the last one year. **Conclusion:** HIV/AIDS has affected several households in diverse ways through frequent illnesses, loss of loved ones, and presence of many orphans and vulnerable children

**Keywords:** *PLWHA, HIV/AIDS mortality, Orphans, Vulnerable Children, Idoma land, Household HIV/AIDS Status*

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## **Introduction**

Since its discovery in the 1980's the human immunodeficiency virus (HIV) and its acquired immunodeficiency syndrome (AIDS) have remained major public health problems in Africa as important causes of morbidity and mortality. Globally, sub-Saharan Africa contributes more than 25 million of the estimated 40 million persons living with HIV/AIDS (PLWHA) and Nigeria is responsible for about 9% of this [1]. With a prevalence of 4.1% in 2010, Nigeria is the fifth worst affected nation in the world after South Africa, India, Zambia and Ethiopia, and it was estimated that over 4 million Nigerians were HIV positive by 2011[2]. The prevalence rates in the 36 states of Nigeria varied from 2.5% in Kebbi and Katsina States to 8.4%, 9.3% and 12% in Federal Capital Territory Abuja, Benue and Cross River States respectively [2]. The HIV epidemic in Nigeria has been traced to factors many of which are intertwined with socio-cultural practices, and related behavioral and biological indices. The dominance of heterosexual intercourse as the main mode of transmission of HIV is largely responsible for the stigma of promiscuity attached to HIV infection even when people are not sexually infected [3]. This coupled with factors such as

socio-cultural beliefs and practices, low literacy level, poverty, ignorance, diseases, poor adherence to antiretroviral therapy, antiretroviral therapy (ART)-related toxicities and malnutrition have contributed to the burden of HIV/AIDS in many communities where the disease is still on rampage, maiming and killing majority of the workforce and leaving many children as orphans.

The fight against HIV/AIDS has posed enormous challenges to Africa, generating fears that success in its control may be too difficult or even impossible to attain [4]. Mluma [5] reported that since the epidemic started, 13.7 million Africans have died of AIDS-related causes. Between 1998 and 1999 alone, more than 2.8 million Africans died of AIDS, mostly people of the reproductive age bracket (15 – 46 years), who are also the economically active group, thereby causing significant disruptions of households structure and family lives [6]. In some cases, children became orphans and family heads after both parents had died of AIDS [7]. Since 1986 there has been an increase of between 15% and 20% in AID-related infant mortality and 48% maternal mortality in Zambia and Kenya respectively, a phenomenon earlier predicted for Africa by the UNAIDS [7-9]. Both the UNAIDS and UNICEF reported that orphans whose parents died from AIDS were at greater

risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes [10-11]. Stigmatization and discrimination associated with AIDS further deprive them of basic social services, inheritance and property, access to healthcare, and education as these children are themselves assumed to be HIV positive. Reports from Zimbabwe showed that most secondary school students whose parents died of AIDS never returned to school as most of them found odd jobs and became street children [11].

Nigeria has one of the largest and fastest growing populations of orphans in the world. Between 2001 and 2003, about 350, 000 to 800,000 children were orphaned by AIDS [12, 13], and by 2009, the number rose rapidly to 2.5 million [14, 15]. Benue State in north central Nigeria, being one of the most prevalent areas in the country, bears a huge portion of this burden.

The objectives of this survey were therefore:

1. To investigate the prevalence of HIV/AIDS on households in Idoma-speaking communities of Benue State
2. To describe HIV/AIDS-related morbidities and mortality among PLWHA,
3. To evaluate the impact of these on orphans and vulnerable children (OVC) among the Idoma-speaking communities of Benue State

**Table 1: Causes of death of PLWHA’s children**

	Causes	Frequency	Percentage (%)
1	Missing data	52	56.5
2	Illness of unknown origin	23	25.0
3	Vomiting/stooling	5	5.4
4	Fever/convulsions	4	4.3
5	Body rashes	3	3.2
6	AIDS	2	2.2
7	Stillbirths	2	2.2
8	Measles	1	1.1
	Total	92	100

Source: PLWHA survey (2011)

Missing data – 52

## Methodology

**Design:** a combined qualitative and quantitative study.

**Site and community selection:** The Idoma land was selected for this study because of the reported high prevalence of HIV/AIDS there [16, 17]. The major ethnic group is Idoma; a homogenous ethnic group (with dialectical differences) comprising the people in Otukpo, Adoka and Ugboju; Edumoga in contrast to Agila, Otukpa, Orokam, Agatu, among others found in nine local government areas (LGAs) [17]. These LGAs are found in three dialectical clusters thus: Idoma West (i.e. Okpokwu and Ogbadibo LGAs), Idoma North (Otukpo, Ohimini, and Agatu) and the Agila-Igede

cluster (Ado, Obi, Oju, and Apa LGAs) [18]. Three LGAs (Okpokwu, Otukpo and Ado), each from the three dialectical clusters were selected, and then stratified into rural and urban settlements. Households were then systematically selected from each of the settlements.

**Sample selection:** One hundred and twenty two PLWHAs were selected through availability method. PLWHAs that were present at the treatment centres on the days of survey and were willing to participate formed the sample. The researcher (s) visited and administered questionnaires over a 2-week period. Nine health workers, including two monitoring and evaluation (M&E) officers and nine community/group leaders were the facilitators/key informants while household respondents were adult males in selected households (except where the males were not available). The males were selected because Idoma land is a patriarchal society where males are the heads of households and thus usually provide information on the status of households.

### **Ethical considerations**

Permission for the research was obtained from the Local Governments and selected hospitals. Community leaders also granted permission to access the respective communities while

household heads equally gave permission to undertake the study.

Consent was obtained from respondents after the goal of the study was explained to them, and they were told that participation was voluntary and responses would be confidential. All the participants were given stipend for transportations to and from the treatment centre.

### **Data Collection**

a. Qualitative data were collected through focus group discussions (FGDs) and in-depth interviews (IDIs) conducted by the principal investigator:

i. From two FGDs conducted with eleven HIV/AIDS patients at one of the treatment centres (one group with five males and the other with six females) through a guide.

ii. From IDIs with heads of households conducted in Idoma language by the principal investigator

iii. From IDIs with nine health workers in the three selected health care units: a medical doctor, two heads of nursing units, an administrative head of a hospital, two HIV coordinators of LGAs, two M and E officers of treatment centres, and one health worker in Voluntary Counselling and Confidential Testing (VCCT) unit from one of the hospitals.

b. Quantitative data were derived from retrospective study of records of two HIV/AIDS

treatment centres through the help of M and E Officers of the respective centres. Data consist of 6 years records (2002, 2003, 2004, 2007, 2008 and 2009) in one centre, and 4 years (September 2006 to December 2010) in the other centre. While records in the first centre were manually sorted, those at the second centre were electronically retrieved. Both data were transferred into the proforma developed by the researchers.

**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 (translated and) transcribed. All the qualitative data were also 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 PLWHAs. The quantitative and qualitative information were triangulated to meet the study objectives. Results of HIV screening, (both routine and antenatal screening) from both treatment centres were analysed.

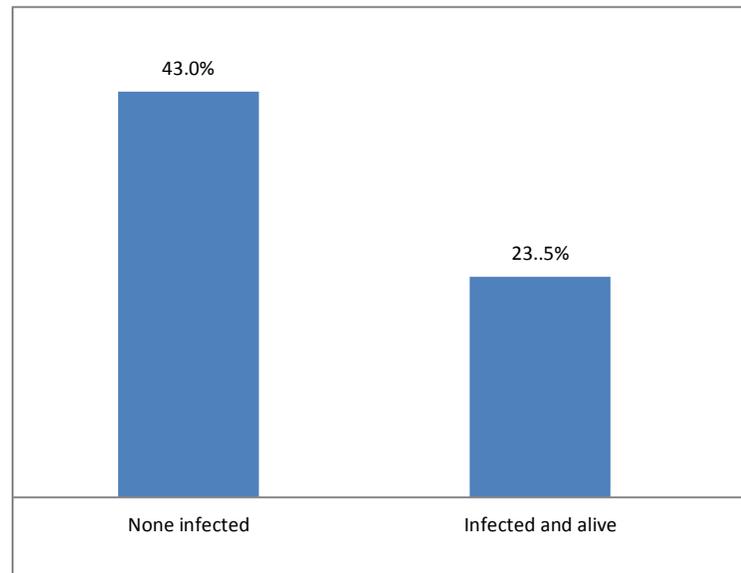
## Results and Discussion

### HIV/AIDS Mortality and OVC Situation

HIV/AIDS related deaths of young people and heads of I  
*At a point in the early 1990s, PLWHA died every day of AIDS-related complications. All social and economic activities were disrupted during burials because traditionally the Idoma culture requires between three and six months of mourning periods and elaborate traditional funeral rites for a deceased community person.*

A Youth leader interviewed captured this by stating that:

*There are households in our immediate environment made desolate. In AiAba community here, there are households where both the husband and wife have died from AIDS. In fact, there are homes where a man h*



Source: Household survey (2011) N=158

**Fig.1: HIV prevalence in households/families**

*having three or four wives contracted the disease and all of them died.*

The women leader at Edumoga reiterated this impact on the community when she showed the researchers some households that were deserted, and said:

*Many families are desolate... No father, no mother. It is a very pitiable situation; AIDS has killed their parents.*

Similarly at Igumale, informants stated how male HIV/AIDS persons came back from cities and died at home. In addition to the death of the men, it was observed that even

*...their children and their wives at times come back home; and after about a year or so, most of them have also gone (died).*

A health worker at Okpoga, when reacting to questions on what she considered the socio-economic consequences of HIV/AIDS in Idoma land said that:

*... before the (ARV) drugs came, only God knows how many people had died of AIDS. Many families were crumbling; the young people and the old were all dying, living behind the older generations and orphans. We have now OVC (orphans and vulnerable children) here and many of them come for meeting here once a month. Many children are also becoming positive.*

In most narrations on the impact of HIV/AIDS by informants, increased mortality related to

the epidemic was mentioned (Table 1). Related to the demise of parents and other members of the families, informants also acknowledged a worsening situation of children orphaned by AIDS, as reflected in the above description of the HIV impact by the health worker. A traditional ruler in one of villages also said “*many children are in this community whom their parents died of AIDS*”.

Although all informants stated that these are common in Idomaland and are cared for by family members, some informants narrated how some of these children are subjected to psychological and physical abuses. A youth leader at Edumoga said:

*...some of these orphans are usually taken to the relatives of the dead parents. But as you know we human beings are not the same. Many of these orphans are insulted, how AIDS has killed their parents. Many people have told children orphaned by AIDS such terrible things. When these children hear such things they become very sorrowful. That's why we talk to people to be very careful at least for the sake of their children.*

Although, these children face such challenges, and the death of parents due to AIDS, children heading households are not common in Idoma land. Orphans are normally in custody of aiyi'-onmapu (adult members of ole, ipu-oma and ipu-opu). However, the challenges faced by

these orphans have been acknowledged by some informants. The men's group leader cited situations where the children of deceased AIDS patients stopped going to school or had to be transferred to inferior schools. He said that "most of the children (orphaned by AIDS) have stopped going to school because they don't have money and so on".

However, this is not peculiar to orphans due to AIDS alone; as all orphans suffer same fate, except that AIDS orphans suffer stigmatization. Apart from the fact that parents are dying, the children of the PLWHAs are also dying. Data from PLWHA survey showed that 92 (75.4%) of them had between one and twelve children and 57.6% of them reported the death of between two and four children from causes listed in Table 1. 18 (53%) were reported to have died at less than one year old, 11 (32.3%) at 1-5 years, while 2.9% at 6-10 years and 16-20 years each.

The in-depth interviews on impact on OVC revealed that many children were orphaned by AIDS. A community leader at Otukpo said that:

*All dependents (children) left behind by dead HIV/AIDS patients are healthy, and all relations cooperatively take care of these dependents without any discrimination... there are support services for children who are affected by AIDS, those whose parents have*

*died. Such services are very common in this environment. One or two non-governmental organizations (NGOs) are doing one thing about it. Otabo Care Support Group is doing something about it. But not much is being done. Idoma Imeli assisted to some level, but it no longer has the finances to carry on such services.*

These services reportedly have challenges of sustainability and funding. The informants said that most of the sponsors of these supporters no longer send resources as they used to and that there are no local sponsors to continue the services to the orphans. However, the community is making concerted efforts to assist in the care of orphans. Most of the community leaders confirmed their efforts toward integrating orphans into the community productive life. For instance, a traditional ruler narrated the community contribution to orphan care thus:

*In fact, some of children left behind by "PLWHA" who died are being taken care of by immediate relations and at times we urge the community to make donations for the upbringing of such children.*

This means that members of ole or the nuclear family still takes care of children orphaned by AIDS in the community. These families are then assisted by other members of the community on appeals from community

leaders using a framework provided by UNAIDS/UNICEF for protection and support of OVC [19, 20].

On whether the care of children orphaned by HIV/AIDS differed from children orphaned by other diseases, a Men's group leader said:

*We don't normally discriminate as such because we consider that both of them were orphans and we normally treat them equally. In fact, at times we even give more preference to those orphans of HIV/ AIDS people because most times both father and mother are dead, no one is being left take of them (sic).*

From the foregoing, care of children orphaned by AIDS does not seem to differ from care of other orphans in Idomaland. The traditional nuclear family is still responsible for children of deceased relations irrespective of the cause of death.

### **The HIV/AIDS Status of Households**

It was found that 90 (57%) of the 158 households surveyed either have current HIV positive members or a relation who had died of HIV/AIDS. 53(33.5%) of the households had recorded the deaths of HIV positive relations while 37(23.4%) have at least one HIV positive member alive. The remaining 68 (43%) of the household were not afflicted (see fig.1). Table

2 also showed that most household respondents had friends (23%), neighbours (19%), father

(12%), brother (9%), sister (8%) and other relations infected by HIV.

All the households surveyed however reported having either assisted a HIV positive person or have contributed to families who have lost members due to AIDS. Socio-cultural practices in Idomaland where chronic illnesses and death-related ceremonies like burials and funerals require communal contributions from ipu-opu and ipu-oma (extended families and lineages respectively) could be responsible for this. This is probably what previous reports described as "AIDS has affected all households" in Idomaland [16, 21].

Data obtained from both routine and antenatal HIV screening records (2001 – 2010) at the two treatment centres reflect the hospital-based HIV prevalence and antenatal HIV rate among residents, including pregnant women in the study area. These gave an overall HIV prevalence rate of 20.2% (ranging from 14.3 for males to 24.5% females), and an antenatal HIV rate of 7.1% (Table 3). This indicates an urgent need for Prevention of Mother to Child Transmission (PMTCT) HIV services in the area [22].

There were fears that the incidence the HIV/AIDS was on the increase in Idomaland.

All the community and group leaders interviewed expressed serious fears about this trend. Most of them stated that the factors responsible for this were: serial marriages by PLWHAs to unsuspecting people; unprotected sex by the PLWHAs who believe that neither they nor others can be infected or re-infected once they were on ART. This trend was reflected by a discussion between the principal investigator and an informant in which he said that:

*...a recent unconfirmed report from one of our higher institutions during an HIV/AIDS awareness campaign meeting worried us. We don't believe it but since you are here, let me mention it. They said they did a research and found that among our children in secondary schools 8 out of 10 tested positive. Like I said we don't believe that because the disease has reduced in our land.*

**Prevalence of opportunistic infections (OIs)/ malignancies.**

Records at two centres indicated an increase in the prevalence of some opportunistic infections (OIs) such as pulmonary tuberculosis (PTB), skin infections and skin cancers. For example, in 2002, a total of 47 cases of PTB were recorded while in 2003, this increased to 27 (9

cases of PTB, 5 skin diseases and 13 cases of diarrheal diseases).

**Conclusion**

HIV/AIDS deaths and orphans and vulnerable children constitute major problems in Idomaland. Households in the area have also been affected directly or remotely by the epidemic. Contraction of family sizes, evidenced by reports of deaths of young members and subsequent desolate households was found to be a common phenomenon in Idomaland.

**Table 2: Distribution of PLWHAs and their relationship to household respondents**

S.No	Relationship of PLWHA household respondents	Frequency	Percentage (%)
1	Friends	21	23.3
2	Neighbors/community members	17	18.9
3	Father	13	14.4
4	Uncle	11	12.2
5	Brother	8	8.9
6	Sister	7	7.8
7	Aunt	4	4.4
8	Nephew/niece	3	3.3
<b>Total</b>		<b>84</b>	<b>100</b>

Source: Household survey (2011) Missing data = 6 (6.7%)

### Recommendations

Community focused interventions and programmes are required to mitigate these adverse effects while an accurate quantitative means of measuring deaths from HIV/AIDS in the community should be undertaken [23].

**Table 3: Results of HIV Tests in the Study Area (2001-2010)**

Test	Positive		Negative		Total	
	Freq	%	Freq	%	Freq	%
VCCT:	2458	14.3	14730	85.7	17188	
Male	5732	24.5	17671	75.5	100.0	
Female					23403	100.0
ANC Screening	752	7.1	9801	92.9	10553	100.0
<b>Total</b>	<b>8942</b>	<b>17.5</b>	<b>42202</b>	<b>82.5</b>	<b>51144</b>	<b>100.0</b>

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

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