

Impact of AIDS on rural livelihoods in Benue State, Nigeria

Implications for policymakers



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Contents

Contents	4
Glossary	7
Executive Summary	8
1 Introduction	13
1.1 Why this study?.....	13
1.2 Nigeria's and Benue's Response to rising HIV/AIDS prevalence.....	14
1.3 Outline of the Report.....	15
2 Study Design.....	16
2.1 Objectives	16
2.2 Livelihoods Framework.....	16
2.3 Determining methodology, research questions, indicators and variables	17
2.3.1 Ethical Considerations.....	18
2.3.2 Site Selection and Study Population	18
2.3.3 Proxy Indicators of HIV/AIDS	20
2.3.4 Data Collection Methods and Analysis.....	20
2.4 Wealth ranking methodology and indicators.....	22
2.5 Strengths and Limitations of this Study Methodology.....	23
3 Basic services and social structures in Benue State	26
3.1 Infrastructure and Basic Services in Benue.....	26
3.2 Social Organisation.....	28
3.2.1 Traditional social structures.....	28
3.2.2 Community-based organisation.....	28
3.3 Financial services	29
4 Livelihood activities and assets.....	31
4.1 Livelihood Activities.....	31
4.1.1 Overview primary and secondary occupations.....	31
4.1.2 Farming.....	32
4.1.3 Common pool resources	37
4.1.4 Non-farm activities	37
4.1.5 Mobility and Migration.....	38
4.2 Wealth ranking of the study population	39
5 Epidemiology and Demography.....	41
5.1 Different Stages of the Epidemic	41
5.2 Review of Epidemiological Surveys.....	42
5.3 Analyses of Proxy Indicators for AIDS collected during the Domicile Listing	43
5.4 Chronic Illness and Mortality: Trends over time in household survey	44
5.5 Household Survey: The number of orphan events over time	45
5.6 Are chronic Illness and Death Related to HIV/AIDS?.....	46
5.7 Demographic Impact.....	49
5.8 Concluding Remarks	50
6 Responding to Chronic Illness and Death and the Implications for Livelihood Strategies.....	53
6.1 Being affected.....	53
6.2 Coping or surviving	54
6.3 Direct Costs of Chronic Illness and Death	55
6.3.1 Loss of labour	55
6.3.2 Time spent in mourning and funerals	56
6.3.3 Responding to labour constraints.....	57
6.3.4 Expenses during illness and after death	58
6.4 Coping with extra expenditure	60
6.5 Diversity in coping based on ethnic or wealth differences.....	62
6.5.1 Differences in coping strategies between Idoma and Tiv areas.....	62
6.5.2 Differences in coping according to wealth and gender	63
6.6 Implications of morbidity and mortality for the asset base.....	65
7 Local support systems	67
7.1 Community Organised Support and Welfare.....	67

7.2	Support Systems for the Sick	67
8	Vulnerability of households to the effects of illness and death	71
8.1	Vulnerability of livelihood strategies.....	71
8.2	Orphans, Widows and the Elderly	75
8.2.1	Tiv Widowhood	75
8.2.2	Idoma Widowhood	76
8.2.3	Widowerhood.....	77
8.2.4	Orphanhood.....	77
9	Perception of HIV/AIDS in the Study Communities	79
9.1	Local perceptions of HIV/AIDS and implications for prevention and care.	79
9.2	HIV/AIDS Stigma and its affect on assistance for PLWHA's	80
9.3	Awareness raising and community based education activities.	82
9.4	Concluding remarks.....	83
10	Discussion, conclusions and recommendations	84
10.1	Epidemiology and Projections of the Consequences of Increasing Mortality.....	84
10.2	Direct implications of illness and death	85
10.3	Outcomes of chronic illness and death for livelihood security and well-being	86
10.3.1	Responding to chronic illness and death and impact on livelihoods	86
10.3.2	Lack of cash, lack of investments.....	87
10.3.3	Changing livelihood activities	88
10.3.4	Reduced food and nutrition security	88
10.3.5	Social networks and safety nets	89
10.4	Vulnerability to the impact of chronic illness and death.....	90
10.4.1	HIV/AIDS in a context of growing poverty	90
10.4.2	Widows, orphans and the elderly	91
10.5	Impact on rural services.....	92
10.6	Opportunities for action.....	94
10.6.1	Eradicating Stigma	94
10.6.2	Care and support for PLWHA.....	96
10.6.3	Mitigation of the impact of chronic illness and death.....	97
10.7	Time is running out, but it is not too late yet.....	99
	References	101
	Appendix 1: Overview of studies on the impact of HIV/AIDS on livelihoods and agriculture.	106
	Appendix 2: Benue State map	110
	Annex 3: Local criteria for the different wealth categories	112

List of tables

Table 2.1: Methodology used to select study sites	19
Table 3.1: Community characteristics	27
Table 3.2: Membership of community organisations by gender.....	28
Table 4.1: Occupations of heads of households in Idoma, Igede and Tiv land.....	31
Primary occupations of heads of households	31
Secondary occupations of heads of households	31
Table 4.2: Cultivation of food crops in the three ethnic zones.....	33
Table 4.3: Cultivation of cash crops in the three ethnic zones	33
Table 4.4: Average land size under cultivation by sex of head of household, by zone..	35
Table 4.5: Reasons for joining or leaving households.....	38
Table 5.1 HIV prevalence by year amongst pregnant women attending antenatal care clinics in Benue State from 1991-2001	42
Table 5.2 Summary of results of HIV Prevalence, amongst pregnant women attending antenatal care clinics in Benue State, 2001	43
Table 5.3 Results of HIV Prevalence by age group, amongst pregnant women attending antenatal care clinics in the North central zone (including Benue State), 2001	43
Table 5.4: Characteristics of study households	44
Table 5.5: Relationship of chronic illness and death with HIV/AIDS-related causes	46
Table 5.6: Chronic illness, death and level of HIV/AIDS affectedness by locality.....	47
Table 5.7: Characteristics of AIDS-affected and non-AIDS affected individuals and their households	48

Table 6.1: Average number of hours spent on care per week.....	55
Table 6.2: Average number of days attending funerals or spent in confinement over the last 12 months	56
Table 6.3: Medical costs over the 6 months preceding the interview and funeral expenses for AIDS-related and not AIDS-related cases of illness and death.....	59
Table 6.4: Overview of coping strategies to pay for extra expenses.....	61
Table 7.1: Affected households receiving support for various activities	68
Table 8.1: General classification of households according to vulnerability of illness and death	74

List of figures

Figure 2.1: Livelihoods approach and conceptual framework	17
Figure 5.1: Stages of the epidemic.....	41
Figure 5.2: Households that have lost a person by zone and by year	45
Figure 5.3: Number of orphan events per year	45
Figure 5.4: Male and female population of sites with suspected high and low AIDS prevalence.....	52
Figure 6.1: How do Idoma and Tiv households pay for medical and funeral expenses.....	63
Figure 6.2: Coping strategies of Tiv households with different land sizes.....	64
Figure 6.3: Coping strategies of Idoma households with different land sizes	65
Figure 7.1: Relationships within the social network	69
Figure 8.1: Schematisation of trends in asset-endowment in the course of the illness, according to levels of vulnerability	72
Figure 10.1: Mortality rate among BNARDA staff	93

List of Boxes

Box 1.1: Scale of the challenge- Selected data on poverty in Nigeria.....	13
Box 3.1: The functioning of local savings and credit associations: <i>Adashi</i> and <i>Bam</i> ...	29
Box 4.1: BNARDA's support for women farmers.....	36
Box 6.1: Affectedness: a dynamic process	53
Box 6.2: Coping or surviving?	54
Box 6.3: Putting expenses in context	59
Box 8.1: Slipping into poverty	72

Glossary

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drugs
BENSACA	Benue State Action Committee on HIV/AIDS
BNARDA	Benue State Agricultural and Rural Development Authority
CBO	Community Based Organisation
CEC	Communication and Extension Centre
CIP	Chronically Ill Person
CSO	Civil Society Organisation
DFID	Department for International Development
FAO	Food and Agriculture Organization of the United Nations
FOS	Federal Office for Statistics
ha	Hectares
HBC	Home Based Care
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
KIT	Koninklijk Instituut voor de Tropen (KIT) (The Royal Tropical Institute of the Netherlands)
LACA	Local Action Committee on AIDS
LGA	Local Government Area
MAP	Multisectoral AIDS Programme
MTCT	Mother To Child Transmission
N	Naira (Nigerian currency)
NACA	National Action Committee on AIDS
NCS	National Center for Statistics
NGI	Non-Governmental Individual
PLWHA	People Living With HIV /AIDS
PRA	Participatory Rapid Appraisal
SACA	State Action Committee on AIDS
SADC-FANR	Southern African Development Community, Food, Agriculture and Natural Resources Vulnerability Assessment Committee
SD	Standard Deviation
SPSS	Statistical Packages for Social Sciences
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
USAID	United States AID
WID	Women in Development

Executive Summary

Nigeria is in the grip of a growing HIV/AIDS epidemic with Benue State recording one of the highest State level infection rates: 13.5% in 2001, which will have a devastating impact on individual lives and livelihoods.

HIV/AIDS is not the only crisis that rural people have to deal with. The downturn in the Nigerian economy is also hitting Benue State. Public investment in infrastructure, water, health, and education facilities is limited, resulting in poor basic service delivery. The economy in Benue mostly depends on agriculture, spin-off activities such as processing, trading and casual labour, and migration. Farming is under stress due to worsening terms of trade, and input markets that are not functioning well. Over the past decade, farming has actually become more labour-intensive per unit of harvest, a development that increases the vulnerability to shocks.

Epidemiology and demography

This study investigated the impacts of HIV/AIDS on rural livelihoods in Benue. Twelve study sites were selected to represent the variety of livelihoods in Benue State and the main ethnic groups. In each site, a qualitative research was carried out. Subsequently 508 households were selected at random for a household survey.

Data collected on demographic change in Benue state as well as proxy indicators for the spread of AIDS all indicate the same trend: more deaths and more orphans since the beginning of the 1990s. An analysis of the time trends for the year in which children became orphans also shows an increase from 5 reported orphan events in 1997 to 60 reported orphan events in 2002 amongst the 508 study households. Because the increase in orphan rates lags behind HIV infection levels by about 10 years, it is expected that Benue State will face a major increase in the number of orphans in the near future.

The percentage of those households reporting an adult death aged 15-49 years in the past 5 years, increased from 0% in 1997 to 5% in 2002 for the Tiv Households and from 2% in 1997 to 14% in 2002 for the Idoma and Igede households. Of the households with chronic illness and death, 34% were AIDS-affected, according to the definition used in this study: either HIV/AIDS or at least two AIDS-related symptoms were reported. This corresponds to 6% of all study households. Considering the widespread level of stigma attached to HIV/AIDS this likely to be an underestimate.

HIV/AIDS is affecting households of all wealth categories. There was no statistically significant difference between the ethnic groups. Primary occupations of persons living with a chronic disease or who are deceased are significantly different from those of heads of households with no illness or death. Persons who were ill or died are more often (30-40%) traders or working as civil servants whilst head of households were more often farmers (85%). PLWHA on average are 29 years old and do have on average 2.4 dependents. There were significantly more women (61%) among the AIDS-affected cases than in the non-AIDS affected cases (39%).

Responding to chronic illness and death

The direct implications of illness and death can be split into two categories. Firstly, there are direct cost implications due to increased medical and funeral expenses. In addition 66% of the affected households lost the income and 87% other type of contributions from the ill or deceased person, and 50% of households lost income and contributions from the caregiver.

It was found that medical and funeral costs in AIDS-affected households amounted respectively to 38,000 and 19,000 Naira. Affected households use their reserves (25%),

liquidate assets (23-70%), attempt to generate extra cash in other ways (loans 75%, casual labour 8%, other work 25%), receive contributions from others (87%), and reduce their expenditure to pay for the increased medical and funeral expenses. Variations between households are based on differences in asset base, ethnic background as well as gender and age of the head of the household.

Around one fifth of the households are taking an advance on future earnings and production capacity by reducing their investment in farming (19% reduced expenses on hired labour), stopping the payment of school fees (12%), starting to work as a casual labourer at the expense of their own farms (8%) or selling land (only one household). In this study, 17 % of the households reported using these potentially erosive coping strategies, half of them were female-headed households. Given the projected spread of the epidemic, it is likely that more households will need to use erosive strategies in future when alternatives are no longer available. Trade-offs may have to be made between a household's maintenance of current food security and consumption levels and its protection of future income generating capacities

Secondly, there are labour and income implications due to an absolute loss of labour as well as the reduced productivity of the ill person and the caregiver, which affects their usual livelihood activities (farm, business, schooling, housekeeping, childcare, leisure), as well as time consuming mourning rituals. Moreover, psychological stress and a lack of concentration are reported to further affect the conduct of these activities. Strategies to alleviate labour constraints include the use of hired labour, increasing the workload of other family members, calling upon community-based organisations or reducing/abandoning a livelihood activity.

Poorer household with no reserves have fewer choices. Relatively well-off households may have more produce and plant material in store, more livestock, more savings or other sources of income than poorer households. Selling off part of these goods will not affect next season's farming operations. However, even when next year's cropping season is not in danger, coping strategies will reduce their capacity to invest and spend on future projects.

Initially, ill people and their close relatives prefer to hide their difficulties from others and opt for strategies that lie within the household's means and are not visible for others. It is only when they can no longer cope on their own that they will involve outsiders in their efforts to deal with the situation.

First line relatives, with assistance of other members of the extended family, were identified as the most important source of support for the ill and the bereaved, with the community groups to which household members belong also occasionally providing some help. No faith-based or non-governmental organisations as such were found to be involved in care and support activities for AIDS-affected individuals and households in the study communities. AIDS-affected households suffer more from social isolation than households experiencing chronic illness or death from other causes. People withdraw actively from social networks out of fear for rejection and stigmatisation by others; others stop participating because they can no longer afford the contributions.

The direct implications of illness and death are not limited to the ill person and the household where he or she lives. Many more are directly affected because the burden of care is shared among households by moving ill persons, others contribute in cash, kind or labour, or by taking responsibility for the bereaved.

The effects of coping with illness and death go beyond the directly affected households and communities. Resources spent on providing care or on burial can no longer be used elsewhere: be it reserves and savings, consumption, social obligations or planned

investments (housing, education, farm, business, etc). Thirty two percent of households with a chronically ill person and 50% of households experiencing the death of a young adult went into debt to meet their obligations. Also labour and attention is diverted from the caregiver's usual activities. Diverting savings and investments into care and funerals affect the economic development of, families, communities and of Benue State. Losing so many young people undermines the fabric of society.

In Benue State, at the time of the study, ARV treatment was made available to very few selected PLWHA for N10.000 a month. Data on medical expenditures show a preparedness to pay, in particular when recovery is expected. Present levels of expenditure on medical expenses are not enough to pay for ARV treatment. However, these expenditures are already considerable when compared to average income levels, and most likely involve a pooling of resources. The question is how much more can households afford to pay and for how long, without having to resort to irreversible changes in livelihood strategies. Much will depend on the effects of ARV on the PLWHA's capacity to work again and earn an adequate income to pay for such costs.

Projections and implications

Assuming that non-AIDS death rates will not change until 2010, the total death rate will increase from 1.50 to 2.25%, which is an increase of 50%. Benue State is thus facing growing morbidity and doubling of mortality of adults as a result of HIV infections, if ARVs are not made available and accessible.

When projecting the study findings on medical expenses to the estimated spread of the HIV/AIDS epidemic, the total expenditure between now and 2010 in Benue State would equal a total of 9900 million Naira for medical expenses (considering only the 6 month reference period of the survey). The total expenditure of households on funerals of PLWHA will rise to at least 4800 million Naira in 2010, assuming that present practices of rites around burials will not change. These figures do not include the expenditures in kind, nor what households contribute to funerals of relatives, friends and neighbours.

Time spent on mourning and funeral rites for men and women will increase by 50% in conjunction with the increase in death rates. In 2010, Idoma male heads of households are expected to spend 90 days instead of 60 days at funerals and in mourning, their wives will spend even more time (100 days instead of 67). Tiv male heads of households and their wives both spent 22 days at funerals and in mourning according to our survey, this will increase to 33 days in 2010.

An increase in morbidity and mortality affects informal financial institutions if it implies that people have less money available to invest in these associations, more people ask for loans, and more members have problems with repayment. Diverting savings and investments into care and funerals will affect economic development in Benue State : households can invest less, local credit and savings institutions are undermined, productivity will fall, consumption will be reduced, and there will be less demand for hired labour, making it even harder for the very poor to earn a living.

Women experience the greatest burden as care giver, in terms of labour. Widows not only suffer the loss of a husband, but may also be disinherited and blamed for his death. In the past, widows used to be inherited by brothers of the deceased, but this practice is on the decline. The downside is that support for widows and their children is dwindling too. Widows with small children are most at risk of becoming destitute.

Because the increase in orphan rates and of impact more generally lags behind HIV levels by about 10 years, it is expected that Benue State will face major increase in the number of orphans in the near future.

Conclusions

Action is needed in four main areas: eradicating the stigma, preventing infection, strengthening care and support to PLWHAs and care givers; and, mitigating the impact of HIV/AIDS. Impact mitigation includes reducing the direct consequences of illness and death; reducing the impact on livelihoods; and, providing social protection. Orphan-related problems are a major concern for the future. The political will exists to act decisively to prevent the further spread of HIV and deal with the consequences of the epidemic, but efforts on the ground are too limited. Overall, AIDS is still a highly stigmatised disease in Benue State and few PLWHA support groups exist. Too few prevention or care and support interventions are implemented at the grass root level in the study communities.

The challenge for all actors is how best to support existing local safety networks so that they can become more effective without becoming overwhelmed, and how to sustain the productive and reproductive capacity of rural households in view of the demographic and socio-economic effects of the epidemic. Support must build on local initiatives and existing safety nets, avoiding the development of external or parallel support systems, which cannot be sustained. PLWHAs and their organizations, their families, communities and leaders should be central in the development of action programmes.

Three different levels for mitigation impact can be identified: 1) Reduce the immediate effects of illness and death; 2) Reduce impact on livelihoods; and, 3) Provide social protection for the most vulnerable groups.

Reduce the immediate consequences of illness and death

Immediate consequences of illness and death, such as loss of labour, high costs for medical treatment and funerals can trigger a household's downward spiral into poverty.

Funeral, burial and mourning rites are very costly in terms of money and time, making it even harder for the bereaved to restore their livelihoods. Family heads can decide to alter the funeral arrangements and the length of the mourning period. Given that mortality rates are likely to increase in the coming years and the negative impact of these rituals on the livelihoods of many, it is important to start discussions now on possibilities for reducing the costs for the bereaved, while still being able to pay respect to the deceased person and observe customary rites. Dialogue should be promoted between family, community and religious to analyse the consequences of these rituals and identify alternatives.

The appropriate area for action in Benue is not necessarily agriculture, as the technology for growing cassava, one of the more obvious alternatives, is well known. Mechanising soil preparation would require too many changes in farming systems. Improving the availability of tractors as well as of herbicides of good quality, to reduce weeding, would already go a long way in reducing labour requirements. More important seems a better availability of processing equipment for cassava in particular and to reduce the burden of household chores.

Reduce epidemic impact on livelihoods

Poverty alleviation will increase the resilience of households, and is therefore of great importance for affected households. These include productivity of farming, the diversification of livelihoods and creating opportunities for self-employment, not requiring much investment.

Small livestock, even where households own just a few heads, is used to pay for emergencies and other cash needs, but epidemics regularly wipe out these animals. BNARDA has experience in the control of livestock diseases and could elaborate its activities in this field.

Access to casual work or self-employment that provides an income at the end of the day is important for households who need to raise cash quickly. Women, in particular, often turn to agro-processing but there are indications that processing equipment is not widely available while market demand also seems erratic. A sector analysis is needed with a focus on facilitating accessible and affordable processing facilities (see also section on labour saving devices).

Access to credit is essential to improve production and investments, to cushion the impact of the illness and to maintain a diversified portfolio of livelihood activities. Informal saving and credit organizations are the most important source of such services in Benue State. Within a context of informal savings and credit organizations where perceived credit worthiness is key for accessing a loan, a guarantee mechanism can help to maintain access to credit for affected households, a mechanism which is already used by these organisations. However, such systems need to be designed very carefully, and lessons can be learned from micro finance programmes.

The existence of local insurance or social funds to cover the costs incurred through illness or burials can reduce the impact of morbidity and mortality on affected households. Some community organizations already have small funds for such events, but burial organizations do not appear to exist. Social capital is in fact the most important insurance.

Social protection for the poorest

HIV/AIDS will render some households destitute and may leave weaker members vulnerable such as orphans, elderly people and widows, having lost many of their assets. Some PLWHA will be too weak to work and their households may also have a reduced workforce or no more productive assets. It is important to start now with identifying ways for strengthening of existing safety nets internally, as well as with external support. An 'audit' of what already exists and how it really works in practice will be a first step.

Widows and orphans need better protection with respect to inheritance rights, which would render them much less vulnerable. Families can decide not to disinherit widows and protect the rights of orphans, and some do. In particular, community and religious leaders have a role to play in raising awareness on the implication of these practices and initiating protective measures.

Food aid needs to be delivered with caution in order not to undermine local food markets. Groups that should be considered are stunted children, pregnant and lactating women, impoverished female-headed households, households fostering many orphans and the elderly who have lost their children. Food supplementation for PLWHA needs to take their special requirements into consideration, and provide a diet to sustain energy and reinforce their immune system. Food aid needs to be delivered as part of an integrated package of services (income-generating activities, vocational skills training, asset replacement) and at the same time community participation must be strengthened in the design of food aid programmes.

1 Introduction

1.1 Why this study?

Nigeria is in the grip of a growing HIV/AIDS epidemic, with a national adult infection rate of 5.8% in 2001¹. Overall, it is estimated that some 3.3 million Nigerians were living with the HIV virus in Nigeria in 2000. This number is expected to increase to between 4.9 and 5.5 million people by 2005 (FMOH, 2002). The national adult infection rate masks some significant regional variations (0.5–21%).

This study focuses on the state of Benue, located in north central Nigeria. In the 1999 and 2001 national antenatal HIV seroprevalence survey, Benue State recorded the highest State infection rates: 16.8% (1999) and 13.5% (2001). Policy Project estimated that some 325,000 inhabitants of Benue were HIV positive in 2003 out of a total population estimated at 3.78 million. (POLICY Project, 2003). Most of those infected will fall ill and die within the next 5-10 years. Another alarming implications of the HIV epidemic is the emergence of large numbers of orphans. With its high rate of HIV infection, Benue is not exempt. By 2000 it is estimated that there were approximately 139,000 orphans in Benue and by 2010 there will be over 683 thousand orphans (Ssengonzi and Moreland, 2001.)

AIDS has a disproportionate impact on the morbidity and mortality of the most productive age groups. Its impact on households is characterised by a sharp reduction in the available time, labour and other resources of individuals and households, possibly even leading to loss of assets. Because the disease has both a long incubation period and is accompanied by a lengthy period of illness, the socio-economic as well as psychological impact is felt over a prolonged period of time (Ainsworth and Over, 1992). In addition to the suffering this causes, an increase in HIV/AIDS prevalence augments the pressure on health care services, adversely affects individual lives as well as state development and efforts to alleviate poverty.

Nigeria is already a poor country. Nigeria is a federal state with a population of approximately 126 million inhabitants in 36 States and the Federal Capital Territory (FCT) of Abuja (NPC and POLICY Project, 2003). Income per capita was estimated at US\$ 290 in 2001 and as many as 65.5%² of Nigerians were estimated to be living in poverty in 1996 (NCS-data, FOS 1999- see further Table 1). In Benue State, about 29% of its population live in extreme poverty with another 36% considered moderately poor (FOS, Poverty Profile 1999, in Hilhorst and Ogwimuke, 2003).

Box 1.1: Scale of the challenge- Selected data on poverty in Nigeria

Estimated Population ³ (total)	111.3 million (1996)
GNI per capita	US\$ 290 (2001-(www.unicef.org/statis))
Proportion living below income poverty line	65.5% (NCS 1996)
Population living on less than US\$1/ day	66% (World Bank, 2002); 70% (Human Development Report, 2002)
Gini coefficient	0.46 (1995)
Life expectancy for men	50.7
Life expectancy for women	52.6
Infant mortality rate (per 1000 live births)	91.4 (NHS 1996), 105 (MICS 1999)

¹ This infection rate is similar to that of several east and southern African countries about 10 years ago: Kenya 5.6% in 1991, and Malawi 5.5% in 1992.

² Measured as number of people having less to spend than two-third of mean per capita expenditure.

³ As the last national Census was done in 1991, population estimates vary more recently.

Adult illiteracy rate	48.9% (MICS 1999)
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Benue State is often described as Nigeria's food basket⁴ with over 70% of its population listing agriculture as their main source of income.

Concerns about the impact of HIV/AIDS on the agricultural sector prompted Benue State Agricultural and Rural Development Authority (BNARDA⁵), a para-statal organisation of the Ministry of Agriculture and Natural Resources, to request support from the British Department for International Development (DFID) to carry out an impact assessment study to help strengthen Benue's response to HIV/AIDS. Between July 2002 and June 2003, the Communication and Extension Centre (CEC), BNARDA, and the Royal Tropical Institute (KIT), with financial support from the DFID, implemented the stated research on the impact of AIDS on rural livelihoods in Benue State.

1.2 Nigeria's and Benue's Response to rising HIV/AIDS prevalence

The official federal response to the AIDS epidemic is summarised in the HIV/AIDS Emergency Action Plan (HEAP), which took effect in 2001. A tiered multisectoral committee structure comprising the National Action Committee on AIDS (NACA), the State Action Committees on AIDS (SACA) and the Local Action Committees on AIDS (LACA) is overseeing implementation of the plan on both the national and local levels. Some modest achievements have been recorded, notably the periodic sentinel survey and other studies that have generated useful data on the magnitude, trend and characteristics of the epidemic (see Chapter 3). Still, many state and local committees are not operational, reflecting more generally problems with basic service delivery at every level of government.

In Benue, a multisectoral coordinating committee called the Benue State Action Committee on HIV/AIDS (BENSACA) recently superseded the HIV/AIDS Coordinating Committee (BENSHACC), established in 2000. The Women in Development programme of BNARDA, one of the organisations that requested this study, is involved in HIV/AIDS awareness raising activities with female farmer groups. Besides the governmental organisations, there are also numerous civil society organisations (CSO) in Nigeria involved in the struggle against AIDS.

Bilateral and multilateral donors have also been quite active in Nigeria to combat HIV/AIDS. The World Bank is the largest contributor, having agreed to a loan of US\$ 90.3 million for the Multisectoral AIDS Programme (MAP). In addition, FAO is helping the Federal Ministry of Agriculture and Natural Resources in its efforts to mainstream HIV and AIDS into its activities.

DFID and USAID are the two largest bilateral donors. DFID has recently agreed to a £25 million programme that aims at strengthening Nigeria's multisectoral response to HIV/AIDS, in four focal states, including Benue State. In addition, DFID is also supporting a £52 million national programme on Promoting Sexual and Reproductive Health for HIV/AIDS Reduction.

Two bilateral DFID funded projects, a Sexually Transmitted Diseases/Human Immunodeficiency Virus (STD/HIV) Management project and the Benue State Health Fund, were recently completed. These projects emphasized improvements in Sexually Transmitted Infections (STI) management, counselling, HIV testing, Tuberculosis (TB) control, laboratory

⁴ In Nigeria, Benue State is a leading producer of beniseeds or sesame, soybeans, yam, cassava, citrus, mango and rice (Ortese et al., 1999)

⁵ BNARDA is a para-governmental organisation of the Ministry of Agriculture and Natural Resources and presently responsible for agricultural extension and a range of other support services. It represents the Ministry on the State Action Committee on AIDS in Benue State.

quality control, and home-based care (HBC). In collaboration with the Benue Health Fund, community education in selected local government areas (LGAs), a tuberculosis control - DOTS pilot programme (Directly Observed Treatment-Short course), and development of youth-friendly health/STD services have been instituted. The STD management project also formed links with people living with HIV/AIDS (PLWHA) networks and with religious and traditional leaders. The project was not implemented throughout Benue, concentrating instead on the Otukpo and St Vincent hospital in Aliade and selected communities in various LGAs. These projects have also tried to establish links with other DFID-assisted programmes to encourage the mainstreaming of HIV/AIDS into all sectoral development.

There is general awareness that HIV/AIDS is a major problem in Benue State. The Benue State Action Committee on HIV/AIDS (BENSACA) has developed an Interim Action Plan and recently produced a state action plan. Yet, coordination and cohesion between the line ministries involved lags behind (FHI, 2001). Furthermore, policy makers and implementers at the local level have not started to effectively implement action plans.

This study is another important step to support policy makers in Benue State, Nigeria, to mainstream the HIV/AIDS issue into policy development. Other steps that have been taken earlier included a study tour of Nigerian policy makers to Uganda, developing the capacities of policymakers including commissioners; installing permanent secretaries and directors in all ministries and parastatals organisations on HIV/AIDS sectoral impacts and internal-external responses.

1.3 Outline of the Report

Chapter 1 has introduced the necessity for undertaking this study and outlined the importance of HIV infection in Benue State and responses by policy makers. The conceptual framework of this study's methodology is discussed in chapter 2. This chapter also covers site-selection methods, data collection methods, wealth ranking methods, as well as the study's limitations. The social structures and institutions in Benue State, Livelihood activities in Benue State are then analysed in chapter 3 and 4, respectively. Chapter 5 discusses the epidemiological and demographic information gathered during the course of the study, and analyses the prevalence of AIDS. Chapter 6 discusses how affected households respond to the consequences of illness and death of young adults and the impact on these households and the communities. Support given to ill people and practices around mourning and burial as well as widowhood are introduced in chapter 7 and analysed to measure the extent to which they can become sources of vulnerability. Chapter 8 then presents perceptions of AIDS in the communities and issues around stigma. In chapter 9, the findings of the study are discussed and conclusions are drawn concerning the impact of the epidemic.

2 Study Design

2.1 Objectives

This study was designed to analyse the current and possible future impact of HIV/AIDS on rural livelihoods in Benue State in order to:

- Inform the strategic planning of the Benue State Action Committee Against AIDS (BENSACA);
- Inform the planning of the Benue Agricultural and Rural Development Authority (BNARDA) and other agencies involved in support efforts in the rural economy;
- Provide lessons for broader agricultural, rural sector, and poverty-focused policies and planning strategies by federal, state, and donor agencies.

To facilitate the use of the study results by policymakers, care was taken to regularly update stakeholders in Benue State about how the study was set up and its progress. These stakeholders include BENSACA, BNARDA, the Ministry of Agriculture, the World Bank MAP programme, organisations of PLWHA, and representatives of NGOs active in the HIV/AIDS field. A group of stakeholders participated in an analysis workshop of the study's preliminary results.

2.2 Livelihoods Framework

The conceptual framework used in this study is based on the livelihood approach as illustrated in figure 2.1 (Carney, 1998). A livelihood is comprised of the capabilities, assets and activities necessary for living. The different types of assets that may be affected are categorised under human capital, physical capital, natural capital, social capital, financial capital, and political capital. A sustainable livelihood is one that can deal with and recover from various stresses and shocks, can maintain or enhance its capabilities and assets, can provide sustainable livelihood opportunities for the next generation; and can contribute to the net benefits of other livelihoods at the local and global levels in the short and long term (Chambers and Conway, 1992). The policy and institutional context sets the enabling or restraining environment within which the household acts to maintain or improve its livelihood, and may also cause a gender-biased access to resources.

AIDS has a disproportionate impact on the morbidity and mortality of the most productive age groups. Initially, its impact on households is characterised as a shock to its resource base as a result of a sharp reduction in the available time, labour and other resources of individuals and households, possibly even leading to loss of assets. Because the disease has both a long incubation period and is accompanied by a lengthy period of illness, the economic impact is felt over a prolonged period of time and becomes a long wave event (Ainsworth and Over, 1992; Barnett and Whiteside, 2002) The shock turns into a more permanent crisis for households, now experiencing multiple cases of illness and death, for the community when many people are infected and even more livelihoods affected, and society at large. In addition to the human suffering and breakdown of social structures this causes, an increase in HIV/AIDS related morbidity and mortality augments the pressure on health care services, adversely affects economic development, let alone efforts to alleviate poverty.

Factors that determine the level of vulnerability of households to the impact of HIV/AIDS will include, amongst others: their wealth; the type and amounts of assets they possess or have access to; household composition; and the diversity and robustness of their livelihood strategies. The gender of the head of the household is also of influence. The ways in which households try to respond to the shock will ultimately determine its outcome, including factors such as changes in assets, income, level of food security, and social values.

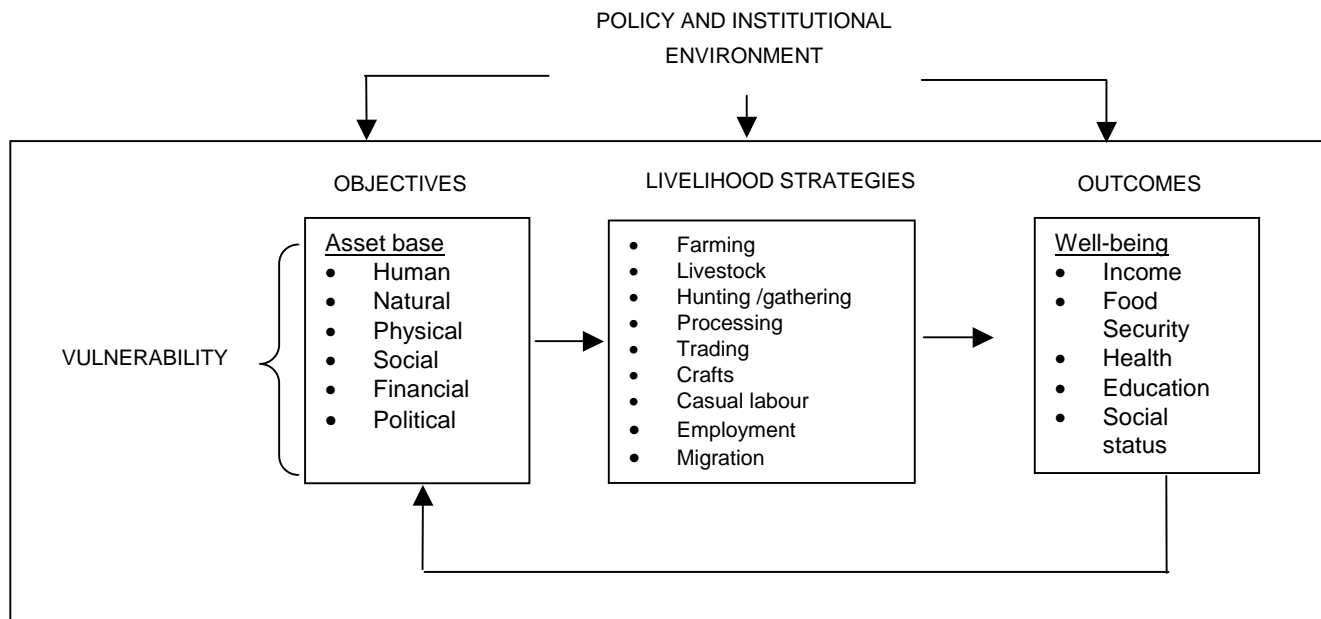


Figure 2.1: Livelihoods approach and conceptual framework

2.3 Determining methodology, research questions, indicators and variables

The outline of the study design was developed in close consultation with stakeholders in Benue State, resource persons and DFID during the study design workshop in May 2002. Decisions were taken on the conceptual framework, sample size and broad planning of the work. It was agreed that the inclusion of 12 different sites would provide sufficient information, taking into consideration the different administrative zones, ethnic groups, and urban-rural differences.

It was decided that, firstly, the study collected demographic and epidemiological information to assess the prevalence of AIDS and identify its impact on Benue's demography. Secondly, this study looks at the effects of illness and death on the livelihoods strategies of men and women (and to a lesser extent communities), how they respond to these effects and with what implications. Thirdly, this study identifies those factors that make some households more vulnerable to the impact of the epidemic than others?

The refining of the research questions was informed by a review of other impact studies. Since the early 1990s, several studies have looked at the impact of HIV/AIDS on livelihoods and household responses, mainly in East and Southern African countries where the AIDS epidemic has reached rates in excess of 30% of the adult populations (Kwaramba, 1998; Rugalema, 1999; Luzobe et al., 2001; Booysen and Bachmann, 2002; Shah et al., 2002; Muwanga, 2002; Yamano and Jayne, 2004; and the Southern African Development Community, Food, Agriculture and Natural Resources Vulnerability Assessment Committee (SADC-FANR), 2003).

In West Africa, the AIDS epidemic initially developed at a slower pace than in East and Southern Africa, but infection rates are rising fast. Other countries besides Nigeria which

exceeded HIV infection rates for adults (15-49 years) of 5% (in 2001⁶) are: Burkina Faso (6.5%) Cameroon (11.8%), Côte d'Ivoire (9.7%), Sierra Leone (7.0%) and Togo (6.0%). Only two studies addressed socio-economic consequences of HIV/AIDS in West Africa— one study by FAO in Burkina Faso (1997) and one study in the Ivory Coast (Bechu et al, 1997). However the first did not address consequences of the epidemic for farming systems and the last was an urban study based on computer projections using few primary data. Since countries have their own unique contexts in which the epidemic develops, the findings of the East and Southern African studies cannot be extrapolated.

The definition of HIV-affected households varied in these studies. Some studies included all cases of chronic sickness or self-reported HIV/AIDS-related deaths or illness, others included the examination of death records by clinicians. Hunter (1990) suggested using orphan count as a way of measuring the impact of the epidemic on the social system, especially the fostering aspect. The size of these studies varies from around 250 to 1400 households. The data collection methods were mainly a combination of household interviews and focus group discussions, while comparative analyses in most cases were carried out using statistical tests. An overview of the most recent studies is given in Appendix 1. Using these studies, a list was made of major issues and variables related to the impact of, and the ability to respond to AIDS; and the indicators used to determine AIDS affectedness.

The present study distinguishes itself from the above-mentioned studies in several aspects. Firstly, it is carried out in an area with a relatively low AIDS prevalence. Secondly, the subject under study is not so much the infected individual but rather the household(s) where the person lives and his/her social network. The choice was made for a community-based selection of respondents instead of a hospital or health service-based sample to avoid a bias related to the accessibility and utilisation of these services. Thirdly, a livelihood's approach is used, measuring impact in terms of human, financial, physical, natural, and social capitals.

2.3.1 Ethical Considerations

Issues concerning illness and death are in general sensitive topics to discuss. This is especially so in the case of HIV/AIDS, which is still highly stigmatised in Benue state. Although the study's aim is to measure the impact of HIV/AIDS, it is not possible to know accurately who is infected with HIV without testing. Most people do not know their status. Others prefer not to disclose whether they are sero-positive, because it remains a highly stigmatised disease in Benue State.

It was therefore decided to focus this study on chronic illness and death among adults, while using proxy indicators to assess whether the HIV virus might be causing the illness⁷. All of the community leaders and households willingly collaborated in the study, although some households refused to allow their interviews to be taped.

Testing the individuals interviewed to establish whether or not they were sero-positive, just for the purpose of the study, was never an option. It would have been highly unethical. Even assuming that people would agree to being tested, after which some might discover that they were HIV-positive, there would be very limited support available. The most they could hope to receive would be some counselling because an efficient referral system has yet to be established in Benue State.

2.3.2 Site Selection and Study Population

Table 2.1 shows the various steps used to select 12 research sites in Benue State.

⁶ Source is www.UNAIDS.org.

⁷ The study proposal was submitted to the Ethical Committee of the Ministry of Health in Benue State in July 2002 and was approved in August 2002.

The first step consisted of a classification exercise of the LGAs according to agro-ecological conditions, major food and cash crops, as well as the opportunities for other non-farming livelihood activities. A stratified sampling technique was used, taking into consideration the different administrative zones, ethnic groups, and urban-rural differences. Benue State consists of 23 Local Government Areas (LGAs) spread over 3 senatorial zones (A, B, and C). The main ethnic groups are the Tiv, the Idoma, and the Igede, who live in distinct LGAs within the state. The Idoma and Igede mainly inhabit zone C, the Tiv inhabit zones A and B. There are few urban centres in Benue State, of which Makurdi is the capital.

The exercise was carried out in collaboration with BNARDA and CEC staff. The resulting selection of three LGAs per senatorial zone, nine LGAs in total, was a purposeful decision to include a large variety of livelihoods that would represent the whole of Benue State, and not part of a random selection process.

Secondly, one ward was selected at random in each of the 9 LGAs. In addition, three peri-urban wards of Makurdi, Gboko, and Otukpo, were deliberately added based on their importance as centres of trade and other markets that offer a variety of livelihood strategies.

Thirdly, 4 localities were selected at random from each of the 12 wards. For this purpose a list of localities was obtained from the National Population Commission in Makurdi, or, where unavailable, this list was provided by the LGA. The first 2 localities of each LGA (24 in total) were included in the household listing exercise; while numbers 3 and 4 were selected as suitable replacements in cases of rejection.

The fourth step consisted of a quick 'domicile listing' that was carried out in the 24 communities by BNARDA staff resident in the locality. The listing of domiciles was based on BNARDA's definition of a household as all those "*eating from one common pot*". For each household (N=4478) in the 24 localities, information was collected concerning the presence of orphaned children and chronic illness and deaths of adults. This information served as a proxy indicator for AIDS prevalence (see following chapter) and was used to determine the final site selection of 12 sites (1 per LGA) including sites with possible "lower" (5% or more below the average) and "higher" household prevalence (5% or more above the average) of chronic illness, young adult mortality, and orphans. It is important to realise that the selected communities are not necessarily representative of the prevalence of AIDS in the whole of Benue State because of the purposeful selection of high and low sites, but they do allow us to identify the local differences in prevalence in the various communities.

These 12 localities became the study sites for the qualitative research and the household survey. The 12 sites are indicated on the map of Benue State (Appendix 2).

Table 2.1: Methodology used to select study sites

Steps	Objectives	Type of section	Number	Distribution
1.	Selection 4 LGA per zone according to diversity in livelihood opportunities & ethnicity	Purposeful	9 LGA	3 LGAs per zone
2.	Selection of 1 ward per selected LGA	Random; stratified	9 wards;	1 ward per LGA
	Selection of 3 peri-urban wards	Purposeful	3 wards	Makurdi, Gboko, and Otukpo
3.	Selection of 2 localities for all 12 wards	Random; stratified	24 localities; 4478 households	2 localities per ward
4.	Selection of localities with relatively low and high incidence, based on incidence of illness,	Purposeful	12 localities out of the 24; and 1 per	1 locality per ward (and LGA): study sites

	death and presence of orphans per locality		ward; 1946 households	
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2.3.3 Proxy Indicators of HIV/AIDS

Information on the prevalence of HIV/AIDS in the study population is necessary for two reasons.

- (1) It is important to show that the burden of chronic illness and death in the study population are most likely linked to the HIV/AIDS epidemic and not due to some other cause, including armed conflict.
- (2) It is necessary to distinguish between sites that are affected to a greater or lesser extent by chronic illness or death of adults, specifically when related to HIV/AIDS, to allow for comparison of livelihoods, impacts, and coping strategies.

This study makes use of a combination of three proxy indicators.

- The first indicator involves chronic illness among adults aged 15-49 years, defined as the number of household members who have been ill for 6 months or longer.
- The second indicator involves mortality among adults aged 15-49 years over the past five years.
- The third indicator addresses the number of orphaned children per household: including both one- and two-parent orphans.

2.3.4 Data Collection Methods and Analysis

Contacting the communities

Before the start of the study, the leadership of the selected LGAs and wards were contacted. The purpose and the methods were explained first, before requesting their permission to undertake the study in the selected communities. Next, the community leaders were contacted and again the methods were explained first, before requesting their permission to undertake the study. For each subsequent step (listing of domiciles, qualitative study, household survey) this approach was repeated.

Domicile listing

A simple domicile listing was undertaken at each of the 24 sites. This listing provided the basis for the random household selection for the household survey. It also offered information on the following: the sex and age of the head of the household; the number of wives; the total number of household members; the number of adults with a chronic illness (more than 6 months) and their age; the number of adults deceased over the past 5 years and the year of death; and, the number of orphans per household, when they were orphaned, their age, and whether they are one- or two-parent orphans. BNARDA staff living in the communities carried out this listing. The 24 communities were covered over a period of 2 to 3 weeks. The data were used to select twelve of the 24 sites for further study (see Table 2.1).

Qualitative research

CEC and BNARDA selected field staff for the qualitative research, while team leaders were selected through consultations with KIT. All of them had had some previous experience with methodology used for participatory rural appraisal and were originally from Benue State. Four teams of four researchers each were trained to carry out the qualitative research during 5 and a half-day, including one field day.

The training sessions of the research team members placed considerable emphasis on the presentation of the aim of the study and the study questions. Great care was also taken to ensure that the confidentiality of the respondents was respected. Each research team

included a member who had counselling experience to respond properly to needs, which might arise during the fieldwork.

The instruments used to conduct the focus group discussions, wealth rankings, and household interviews were developed during this training session and were used by all the teams in a standardised manner. Focus group discussions were carried out with groups of adolescent boys and girls, men, women, and elders. A wealth ranking exercise was used in the selection of households to get a variety of socio-economic backgrounds for the interviews, and level of affectedness by chronic illness and death. The interviews were conducted separately with heads of households and their spouses, as well as with ill people and some PLWHAs contacted through hospital linked support groups. The qualitative research took approximately 5 days per site. The information coming from the PRA was analysed according to specific issues and household case studies were selected to illustrate processes and issues.

household survey

The household survey was conducted at each of the 12 sites after the completion of the qualitative research. The team of interviewers consisted partly of people who had participated in the qualitative research as well as new interviewers who were selected on the basis of their past experience with structured interviews. The entire team received a three-day training session, including a field test before they went out into the communities.

A questionnaire was developed based on issues or gaps identified in the qualitative research, as well as issues that emerged from the literature. The questionnaire consisted of: part A, which contained general questions for all of the households, and part B, containing questions concerning the chronically ill or the deceased. The households were selected at random from the inventory produced by the domicile listing exercise.

The definition of households as used in the survey is: all those “*eating from one common pot*” and all those who reside within the household for most of the year. This also includes students in school whom the head of the household provides for, or wives living elsewhere but still supported by the husband. However, this excludes an adult son who lives in the same compound with his wives and children, but who is no longer dependent on his father’s resources for his daily needs.

The size of the household survey was set at 500 households. This would allow a comparison of subgroups and would in principle include 65-70 households affected by HIV/AIDS, based on an HIV prevalence of 13.5% and an assumption of 1 infected person per household. For each of the 12 sites (N=1946 households), the initial domicile listing served as the basis for a random selection of 508 households (42 or 43 households per site). About 50 households were selected per village in order to replace the households that refused to participate.

The selection of the households for the study population was such that 67% of the households lived in Tiv territory (zone A and B), 25% on Idoma land (zone C), and 8% came from among the Igede (zone C). This repartition corresponds grossly to the proportion of Tiv, Idoma and Igede population in Benue State: 14 (72%), 7 (20%) and 2 (8%).

The information from the household questionnaire was entered and analysed with the statistical software package SPSS, version 11.0. A comparative analysis was carried out for subgroups of the study population, using the Chi-square test in cases of categorical variables and the Student’s t-test in comparing the means of sub-groups for continuous variables. Different parameters were used to compare subgroups: geographical distribution, sex of head of the household, and wealth ranking. The information on the affected households was analysed comparing Idoma and Tiv only, since there were too few Igede cases to be included as a separate group in the analyses.

Demographic study

Finally, a demographic study was completed in 4 of the study villages that were selected on the basis of the suspected level of AIDS prevalence according to data from the 'domicile listing'. Two communities scored high on the three proxy indicators as measured in the domicile listing while the other 2 had relatively low scores.

A full population census of the involved villages was carried out. This included the gender and age of each household member, including those who resided elsewhere. The purpose of this study was to compare the population structures and to analyse whether HIV/AIDS was already affecting the demographic composition of Benue's population.

2.4 Wealth ranking methodology and indicators

An important factor influencing differences between households' coping strategies and the level of impact they experience is their poverty level, or more positively, their wealth ranking.

The purpose of the wealth ranking was to help select representative households in each of the wealth categories for individual interviews, not to compare wealth categories across the study communities. In all 12 study communities, first the research teams discussed local perceptions of well-being and wealth differentiation within the community. In all of the communities, the respondents opted for 3 categories: better-off, in-between, and poor. In one community the better-off were divided into two groups: those who were generous and helped others and those who did not. Annex 3 summarises the perceptions of well-being as defined during the PRA.

The wealth ranking is mostly based on what people owned and the livelihood strategies available to them, but less on how they actually used and managed the resources at their disposal. During the wealth ranking, respondents ignored events like illness or death as criteria that might lead to the "re-classification" of a particular household. In fact, some households were still perceived as well-off or in-between, even though it became clear during in-depth interviews that illness or death had rendered them more poor and vulnerable. Respondents thought, however, that most households without a male head present, belonged to the poorest group of households.

In several communities, the wealth ranking opted for was not founded on reality but seemed more inspired by what people hoped to achieve in life and what they feared. The better-off, for example, were defined as those with a foothold in town and a large house in the village. The poor were those in rags and completely dependent on others. As a result, most households were classified as in-between.

There are many definitions for poverty and wealth that can be applied and there are just as many quantitative methodologies to obtain the information. The accepted definitions based on absolute or relative poverty lines or one's expenditures on food (greater than 70% of income) are based on information that is quite difficult to obtain because people are often unable or unwilling to calculate their monthly income and expenditure. Poverty is also not simply a matter of cash. In the "Voices of the Poor" study, well-being was defined by various poor people in Nigeria as 'being a responsible person who has a pleasurable life, peace of mind, security and independence, and who is popular with the people, is able to marry easily, is able to educate children, is able to patronise private clinics and schools, and who has money, land, a house and good clothes (Narayan et al, 2000, p.23;). Poor people lack social ties, dignity, status, security and hope and are denied the right to a quality of life, which is enabling and empowering (Ayoola, 1999). The goal of households is to increase their physical and material well-being and standing in the community, while maintaining and enhancing their livelihoods and social networks.

The household survey collected data linked to the criteria identified during the wealth ranking exercises. Information was collected on the quality of housing, possession of assets such as: radios; means of transportation and milling machines; total land size cultivated as well as land size cultivated for various food crops and cash crops; total number of household members; and, the number of economically active and economically inactive household members.

Analyses showed, however, that the quality of housing (type of house or roof), or the possession of a radio were insufficient to make an accurate appraisal of the wealth ranking of the households within a community; it merely indicated a difference between rural and peri-urban areas. Eventually, three variables were chosen to classify the level of household wealth. These variables were asset possession, total land size under cultivation, and the cultivation of selected types of cash crops.

The first variable, asset possession, is mainly based on means of transportation, going from the lowest to the highest level of wealth: no means of transportation, a bicycle, a motorbike, or a car. The households that own a milling machine, but maybe no car, were added to the highest category because it demonstrates a certain investment capacity required to possess such an asset. For land size, categories were divided into less than 1 hectare, 1-2.99 hectares, 3-4.99 hectares and more than 5 hectares.

The selection of cash crops was based on suggestions from the wealth ranking (capacity to invest in farming and orchards) and by BNARDA staff. Cash crops reported most frequently in the household survey were citrus or other tree crops grown in orchards, as well as rice, groundnuts or soybeans. The categories are based on the land size under cultivation for these cash crops: none of the cash crops is cultivated; a limited number or less than average land size is under cultivation; and, a larger number or more than average land size is under cultivation.

The wealth indicators are used to analyse differences between the three main ethnic groups, male and female headed households, as well as to compare differences between the coping patterns of 'poorer' and 'richer' households affected by disease and death.

2.5 Strengths and Limitations of this Study Methodology

This research is one of the first larger studies on the impact of HIV/AIDS in West Africa. The focus of the study is broader than the individual person living with HIV/AIDS. It deals in particular with the households in which they live and the network to which these households belong. Moreover, the impact of AIDS on livelihoods is put in the wider context of other changes that are taking place over time in Benue State.

HIV prevalence in Benue State is estimated at 13.5%, but the prevalence of AIDS is lower (around 5-6%). Yet it is AIDS that people end up noticing because the majority of people infected with HIV are probably unaware of their seroprevalence status. In addition, the impact on livelihoods is generally only felt when the HIV infection progresses to full-blown AIDS. The number of affected individuals and households among the general population of Benue State is therefore still low. A random, representative sample of sites would have included too small numbers of AIDS-affected households to be able to detect impact. Therefore we opted for a purposeful selection of sites with an expected higher and lower HIV/AIDS prevalence to allow for comparison. These selection criteria, however, have led to a slight overrepresentation of the Idoma in our study population (25%) as compared to the State population (20%) and underrepresentation of the Tiv (67% instead of 72%). Moreover, the Idoma are overrepresented in the high-prevalence sites (1 site too many) and the Tiv are underrepresented in the high-prevalence sites (1 site too few).

In our study, there are more cases of HIV/AIDS affectedness in Idoma land than in Tiv land, partly due to over representation of sites in Idoma land. It became clear during the analysis that the number of cases was too small to separate the effect of the level of AIDS-affectedness from cultural aspects in the statistical analysis of coping strategies.

Although the household survey comprised of 508 households, with an AIDS prevalence rate of 5 to 6%, absolute numbers of AIDS-affected households remain low (N=40). Thus, one or two misclassified households can have a substantial impact on the figures. Such a misclassification, however, would reduce the probability of finding any significant differences between the sub-groups in any subsequent analyses. This has reduced, for example, to analyse differences in livelihood strategies and coping between female headed households and male headed households as the absolute numbers are again very low (14 affected Female headed households). Since the focus of the household survey was on heads of households, strategies of individual members have not been captured, again reducing possibilities for analysing livelihood activities of women but also of young people, which are not pooled at the level of the household. The concept of a household as unit of analysis has other limitations too, given that ill persons move between households and because of the strength of support networks.

Proxy indicators have been used to identify both relatively highly affected areas and less affected areas. There is a risk of both overreporting and underreporting. On the one hand, stigma concerning AIDS may cause some people to hide the true causes of chronic illnesses and deaths. On the other hand, expectations about possible support for the 'poor' or 'ill' may lead some of those interviewed to exaggerate their situation with regard to the numbers of orphans, illnesses and deaths, as well as poverty levels in general.

Although households for the survey were selected at random from the household listings, without any interference from village leaders, a possible bias may have emerged during the 'domicile listing' because some of the villages' household listings were incomplete. The researchers only discovered during the course of their fieldwork that in the case of some of the larger communities, the enumerators had only listed households in certain neighbourhoods. It is unclear how this choice was made and whether this might have introduced a bias by not selecting the poorest or more distant neighbourhoods, for instance.

The entry for both the qualitative research and the household survey was the head of the household. Both approaches failed to capture those who have lived in households that disappeared before the study even began. During the qualitative research, research assistants tried to identify impoverished or neglected persons, living isolated within larger households⁸, but none were found, suggesting that either these cases do not exist or that the research methodology is not sufficiently adapted to gain detailed insights into intra-household poverty. A longitudinal approach in combination with more in-depth study would better address this source of bias, but would require a longer time frame and more presence of senior researchers.

Research assistants have also tried to identify orphan headed households and female headed households. According to Tiv and Idoma culture, in name, a male person always heads a household. Some informants would therefore insist that in households where the husband had died, another male is now the head, such as his 5-year old son or a distant brother-in-law. Rarely, would they indicate that the widow is the head of that particular household. In practice, however, it is often the widow of the deceased husband who makes the important daily decisions, except when it comes to the sale of land or a child's education for instance when she has to consult first a brother of her deceased husband, although even this differs from community to community. Therefore, care has been taken during the household survey process to identify households *de facto* headed by females according to the study's definition:

⁸ Anecdotic information suggests that some households in Benue (used to) neglect ill persons suspected of having AIDS or another stigmatised disease. They are living in old huts and receive only the most essential care.

households in which a woman is responsible for the daily decision-making concerning production and income generation as well as expenditure.

Both the qualitative research and household surveys consisted of a single visit of several days by the research teams to the communities involved. Using single visits makes it more difficult to capture dynamics of the epidemic, household decision-making and coping strategies, intra-household allocations, and household's relations to others. Although recall questions have been included in order to capture part of these dynamics, the interpretation of differences between past and present situations remains difficult. Again, a study with a longitudinal character is needed to capture such dynamics.

3 Basic services and social structures in Benue State

This chapter identifies and discusses contextual factors associated with the availability of basic services, institutions and social organisations.

3.1 Infrastructure and Basic Services in Benue

Education services in Benue State are generally very weak with an impoverished infrastructure, lack of staffing and low morale of teachers (DFID, 2000). Access to education in Benue State, defined as being able to attend a school no more than 30 minutes away from home, is 85% of the primary school-age children in urban areas and 55% in rural areas. For secondary schools this is 74% and 14%, respectively. In 2001, primary school enrolment in Benue state stood at 76.7% for boys and 68.9% for girls; Enrolment in secondary school was put at 40.7% for boys and 29.2% for girls. Of those attending primary school, 32% of rural children and 57% of urban children were satisfied with school facilities. The main complaints were about poor facilities, strikes, the high costs, a shortage of books and low quality and motivation of teachers. The cost of schooling was the most important deterrent to enrolment (CWIQ, 2001).

As far as health services are concerned, 24.5% of the rural population and 67% of the urban live within 30 minutes of a health facility. For those who consulted health providers, 32% went to private hospitals, 23% to public hospitals, 20% to traditional healers, and only 5% to community health centres. Urban patient satisfaction rates were 74% while 49% of those living in rural areas were satisfied with the care they received. Reasons for dissatisfaction included high costs, unsuccessful treatments, and long waiting times (CWIQ, 2001). Medical services in Nigeria, in general, are outdated and grossly underdeveloped. During the most recent years of military rule, vast portions of the country's infrastructure for services went into total neglect.

The research teams assessed the availability of basic services and infrastructure in the selected communities during their field trips. The communities varied in size from a few hundred inhabitants to several thousands. One site was basically a small town, while two others were rural townships, with busy marketplaces, shops and a variety of services. Three of the communities are located 5 to 15 km away from the nearest small towns. Inhabitants of the remaining six communities live in more isolated areas, meaning that inhabitants have to travel much further to get to markets, school, hospital and so forth. For seven communities, the quality of the roads is a serious problem, with 2 communities being entirely cut off during the rainy seasons. These isolated communities include some of the rural townships and are difficult to reach from the State capital due to poorly maintained roads. In all of the communities, secondary roads are in poor condition.

The two most isolated communities have no primary education facilities and those who do attend must walk to neighbouring communities or live away from home. The primary schools in six of the communities were either supported by an LGA or a church. The remaining four communities also had a secondary school (either private or community-owned) and sometimes a nursery. Communities themselves generally build and maintain their own school buildings.

Parents do their very best to send their children to at least primary school, and preferably a private one if available. Poverty may force parents to temporarily take their children out of school or switch between private and public schools. In two LGAs, some locals pointed out that girls now also attended school. Respondents in one community (near the state capital) noted, however, that few girls stay in school as a consequence of early marriage traditions. Attendance levels for secondary schools are much lower. Students, boys and girls, are often expected to pay their own way or are supported by older siblings (via remittances).

Four communities had no health clinics at all. Clinics in the other communities were all LGA-sponsored, with some having more than one clinic, which are often maintained by churches or private enterprises. Again, communities often built their own health centres and often made contributions to help with the operating expenses, although many health centres lacked adequate supplies. There are chemists and pharmacists in the townships and medicines are often also sold in the markets. Each community had its herbalists and local healers.

Benue's drinking water supply remains problematic: 69% of Benue's urban households and only 19% of rural households have access to safe water (CWIQ, 2001). This lack of access was witnessed in most of the communities in this study. The majority of the population still relies on streams and ponds, many of which dry up during the dry seasons. Water is actually being sold in two communities. Some communities had access to wells. Solar boreholes were available in four of the communities but they could not serve the entire community. Some of the wealthier households may even have a well of their own. Inadequate and unsafe water supply makes PLWHA more susceptible to opportunistic infections.

To conclude, the quality of the infrastructure, the water supplies, and basic services are poor in most of the study communities. These kinds of realities significantly reduce the community's level of well-being, its health status and its educational opportunities. Moreover, the costs of production, marketing and communication are increased, reducing opportunities for improving the local economy and its general well-being.

Local people's contribution in labour, cash and kind to basic services and infrastructure is considerable. The youth are, for example, the main source of labour for construction works and community ceremonies. Growing poverty and a drop in the number of young people available will affect the availability and quality of these services.

Table 3.1: Community characteristics

No. Community	Ethnic group	Location	Primary school	Secondary school	Health clinic	Access to safe water	Land pressure
1	Tiv	Rural-well connected	Y	N	N	-	N
2	Tiv	Rural-isolated	N	N	N	-	N
3	Tiv	Rural centre	Y	Y	Y	+	Y
4	Tiv	Rural centre	Y	Y	Y	+/-	Y
5	Igede	Rural centre	Y	Y	Y	+/-	N
6	Tiv	Peri-urban	N	N	N	+/-	N
7	Tiv	Rural- well connected	Y	N	Y	+/-	Y
8	Tiv	Rural- well connected Peri-urban	Y	Y	N	+/-	Y
9	Tiv	Urban centre	Y	Y	Y	+/-	Y.
10	Idoma	Rural-poor connections	Y	N	Y	-	Y
11		Rural - poor connections	Y	N	N	-	Y
12	Idoma	Peri-urb,	Y	N	N	-	N

3.2 Social Organisation

3.2.1 Traditional social structures

The Tiv and Idoma people have different settlement patterns. The Tiv live in scattered compounds while the Idoma compounds lie in a cluster pattern, resulting in easily identifiable territorial units. For both the Tiv and the Idoma, a compound normally consists of a man, his wife (or wives), their children, and their son's wives, as well as other relatives that live with them. A compound may group several households together. The eldest male is usually the compound head and is always consulted in important matters that might affect the extended family, including problems involving illness. These compounds are united in sub-kindreds and kindreds, each headed by a leader.

Tiv and Idoma mainly practice Christianity, which includes Catholics, Protestants, and Pentecostal groupings. The Tiv and Idoma people have similar leadership patterns. Their leaders preside over traditional councils, known as the Tor-Tiv and Ochi' Idoma respectively. Other members of the traditional councils are called high chiefs or district heads. A traditional leader keeps his position for life, unless he abuses his powers. Women have no authority in the traditional councils. While much of the traditional leader's areas of authority have been siphoned away by state and local governments, they still have an immense influence in rural areas

3.2.2 Community-based organisation

A variety of local organisations are active in these communities. Organisations may function as labour exchange groups⁹, savings and credit associations (such as the "bam", "adashi", etc.), religious groups, craft associations (such as the ice haulers). Some community-based organisations such as a cooperative or widows associations are often branches of larger organisations. Membership is determined by sex, age, profession, family origin, and behaviour¹⁰. The most active organisations and associations meet regularly but attendance is influenced by community events such as funerals.

Table 3.1 presents an analysis of the memberships of several community-based organisations by gender and age range between the research sites. Villagers may belong to more than one community organisation.

Table 3.2: Membership of community organisations by gender

Type of organisation	Men		Women	
	Membership (average)	Range between communities	Membership (average)	Range between communities
Informal finance groups	51%	46–90%	53%	61–88%
Community development organisation	67%	58–100%	38%	2–87%
Church group	61%	56–83%	79%	73–95%
Labour group	37%	0–90%	32%	0–91%

The gender differences in membership is only high in community development organisations, with a male majority. Membership of church groups is common and fairly consistent from

⁹ Members work in each other's fields but also against payment for other people. These funds are used mostly for entertainment purposes, mutual support, or community development.

¹⁰ Various groups stated explicitly that they would not accept thieves and other dishonest people.

community to community. While informal financial institutions exist in all of these communities, *bams* are more important in Tiv land, while *adashi* are more prevalent elsewhere (see chapter 6 for more detail). Labour groups were popular at all of the Idoma sites and some Tiv sites, except in Gboko, an urbanised area with no active labour organisations. Community development organisations exist in most of these communities, but membership varies, as do the levels of activity. The communities in the Idoma and Igede territories reported much higher memberships among community development organisations (over 90%) than those in Tiv land.

Finally, both Tiv and Idoma are organised by “age groups”, which ensures mutual assistance in work situations, financial matters, and other circumstances. The age group notion is important to young farmers who work on a rotational basis on each member’s farm. Later in life, the importance of age groups shifts more toward moral and social support. Wives of deceased members may be allowed to join the age group of their late husbands upon payment of an entry fee.

Both informal and more formal community-based organisations, depending on their activity levels, invest in community services such as school building maintenance, student school fees, health centre, road and church construction, and so forth. These groups raise money in various ways. Many offer their labour in the form of working parties to farmers. Members have to pay an entry fee and may have to contribute at each meeting, and are also asked for extra money on special occasions (including the illness or death of a member or close relative). In addition, they should also be available to participate in the organisation’s activities. Groups also organise special fund-raising activities. Some community associations said they intended to start collective farms to raise money for their organisation.¹¹

3.3 Financial services

Rural people in Benue have almost no access to formal financial services. There are some NGO programmes active that provide access to finance but they do not cover the entire state. Formal banks and NGO-organised savings and credit programmes were not used by those interviewed in our sample. Rural people rely, therefore, almost entirely on informal forms of finance.

There are three major types: loans from family members, friends or neighbours; rotating savings associations such as *adashi*, and savings and credit organisations such as the *bams* (see box 3.1). Pledging or mortgaging was mentioned in relation to labour only. Traders were hardly mentioned as a source of credit for suppliers or customers. There may exist credit arrangements between farmers and agro-processors, who are mostly women. Most investments in farming and trading are self-financed from profits (surplus) made, remittances or using informal financial services.

Adashis are more popular amongst Idoma and Igede while many more Tivs are members of a *bam*. The level of privacy the *bams* offer explains their popularity in Tiv land. Idoma people are also said not to have much experience with the institution of a *bam* but that they are now copying this system. It was also suggested that many Idoma people cannot afford to lock away their savings for a year, as is the case with *bams*. *Adashis* are a more useful method for generating regularly working capital for trading.

Box 3.1: The functioning of local savings and credit associations: *Adashi* and *Bam*

Adashi help people to save money. No loans are given and no interest is paid, but the person responsible for collecting and keeping the money is paid a small compensation. The duration of an *adashi* is generally short (a few weeks to a month) while the amount paid in differs from

¹¹ This information was provided during the FGDs but no concrete examples of a group farming a particular field were reported.

one group to another. In turn, members receive the entire sum paid in by all. The order of pay out is generally determined by using a lottery system.

Bams are more complex and generally function for a period of 12 months and end with profits being spent on buying cattle for Christmas. *Bam* membership is individual and allow people to save but also give loans. The eligibility for credit depends on the amount of savings put in and sometimes a guarantee is required in addition. Loans are given for a fixed period and an interest rate has to be paid. When a member no longer has the money to pay the regular contribution to a *bam*, he or she can stop paying in but will have to wait until the *bam* comes to its end before their savings are returned or, alternatively, they ask for a loan. Not keeping one's engagements will be sanctioned.

Generally, organisers of *bams* and *adashis* have to be trustworthy and should be well-off - that is having property which can be seized in case of default. The advantage of being an organiser of *bams* or *adashi* is 'liquidity': these people have a lot of cash in hand, albeit for a short period, which is of great value in often cash-poor, rural communities.

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4 Livelihood activities and assets

In this section we turn to the local economy, livelihood activities and changes.

4.1 Livelihood Activities

4.1.1 Overview primary and secondary occupations

Table 4.1 lists the primary and secondary occupations of the heads of households interviewed. Most of the interviewees listed farming as their main occupation, although the Igede community also has a relatively high number of civil servants. Other important activities included petty trade, crafts, and fishing, but most of these were listed as a secondary occupation. Very few heads of households were only engaged in one activity.

Occupation differences mostly emerge in the area of secondary occupations. Some are related to specific ecological conditions such as the presence of fisheries, which differ between communities but are found in both Tiv and Idoma land. Many also work as casual labourers and process agricultural produce, activities which are possibly underreported because they are important for women and young people.

Households headed by females tend to focus on activities requiring limited capital outlays or access to fields, such as agricultural product processing, firewood collection, or petty trade.

Table 4.1: Occupations of heads of households in Idoma, Igede and Tiv land

Primary occupations of heads of households

	Idoma (n=127)	Igede (n=42)	Tiv (n=339)	Total (n=508)
None	-		-	-
Farming	89%	67%	81%	81%
Fishing	1%		0%	-
Hunting	-		-	-
Livestock	1%			-
Craftsmen	2%	2%	1%	1%
Petty trade	2%	5%	4%	4%
Big business	-	2%	3%	2%
Civil servant	3%	14%	9%	8%
Other	2%	10%	2%	3%

Secondary occupations of heads of households

	Idoma (n=127)	Igede (n=42)	Tiv (n=339)	Total (n=508)
None			7%	10%
Farming	13%	74%	27%	27%
Fishing	25%	-	5%	10%
Hunting	9%	-	6%	7%
Livestock	3%	-	3%	3%
Craftsmen	15%	11%	12%	13%
Petty trade	32%	16%	37%	34%
Big business		-	1%	1%

Civil servant	3%	-	1%	1%
Other	-	-	-	-

* Differences between zones are statistically significant at $p = 0.008$ for secondary occupation only.

4.1.2 Farming

Farming is, as already noted, a key activity. Even people living in (peri-)urban areas try to cultivate some land if they can. In Benue State, in general, farming accounts for over 75% of the economic activities and employs 88.5% of the working population in rural areas and 25.7% in urban areas (CWIQ, 2001).

Most adult household members, men and women, as well as youngsters, farm a field of their own. The adults spend portions of their yield on the household while youngsters are commonly allowed to keep all their earnings. In addition, many people are also employed on other people's farms in the community. Here, men clear fields, make mounds and ridges, and women do the weeding and harvesting. This labour is usually provided by youngsters, girls and boys, working on their own or with their associations. Adults belonging to very poor households also work as casual labourers in return for money, food, or to pay off a debt.

livestock

Only a few households in Benue State own cattle. The Fulani people used to descend into Benue State to graze their herds during the dry season, but they seem no longer welcome.¹² There are no figures on livestock ownership in the household survey but according to the CWIQ (2001), 58% of rural households own some small ruminants. Goats, sheep, pigs and chickens play an important role in the household economy as they can be easily converted into cash in cases of emergencies, and are also essential for social occasions such as marriages and funerals. Livestock epidemics, however, occur regularly in Benue State. Several people reported that they lost their livestock to an epidemic¹³. A few farmers noted that they now raised ducks and turkeys instead because they are more resistant to diseases. Agriculture in Benue State is mostly dependent on rain. The total rainfall declines from about 1500 mm in the South to 1250 mm in the North of Benue State and the rainy season is bimodal with a total duration of 190 to 220 days.

Crops

A wide range of crops is grown. Crop combinations are dominated generally by root crops (yams, cassava, sweet potato) or grain crops (sorghum or guinea corn, maize, rice, millet). Other crops grown include vegetables (tomatoes, peppers, okra), benni seed, melons, groundnuts, and soybeans. Most crops are used both as food and as cash crops, but many farmers regard soybeans, benni or sesame seeds, rice and groundnuts as cash crops. Farmers are very sensitive to prices and the availability of market outlets when determining the precise mixture of crops they will grow.¹⁴ Trees — both cultivated and "wild" and including citrus, mango, cashew, oil palm, and locust beans — also play an important role in livelihood strategies.

Culturally, the yam is a very important crop for Idoma, Igede and Tiv farmers. It is the preferred staple food and grown by virtually all households (86%). A good harvest requires timely preparation of mounds, planting and regular weeding. Moreover, the yam only performs well in fertile soil. The decline in soil fertility means changing crop mixtures to less

¹² One community accused the Fulani of having chased away their game and destroyed their fisheries.

¹³ African swine fever for pigs; Newcastle disease for chicken;

¹⁴ Crops that some farmers reported having stopped cultivating due to a lack of buyers include tobacco, perishable vegetables, and bambara groundnuts. Cassava cultivation fluctuates in response to the prices of processed foods, but market opportunities vary from community to community. While one village reported that they were abandoning cassava production because of low prices, another reported that the cassava area had been increased because of rising prices.

“demanding” crops such as cassava. Cassava still grows well in less fertile soils, is less sensitive to pests, plant material is cheaper, and cultivation requires less labour. In addition, there is also a larger market for processed cassava products, although prices can fluctuate considerably. Finally, new more productive and resistant varieties have become available to farmers in Benue State. Yam is also demanding in term of labour requirements and investments. Households that lack the labour or cash will end up turning to cassava and sometimes sweet potato, at the expense of yam. Other crops whose yields are vulnerable to a lack of money to pay in time for hired labour and inputs, or to delayed planting and maintenance, are rice, groundnut¹⁵ and soy beans, which are often grown as cash crops.

Table 4.2 and 4.3 show the percentages of study households growing the main food crops and cash crops in the three ethnic zones.

Table 4.2: Cultivation of food crops in the three ethnic zones

	Idoma (n=127)	Igede (n=42)	Tiv (n=339)
Yam *	94%	98%	81%
Cassava	84%	95%	86%
Sorghum*	31%	2%	60%
Maize*	25%	2%	13%
Rice *	18%	10%	1%
Sweet potatoes *	1%	-	22%

* Statistically significant differences between the three zones exist for all food crops except for cassava ($p < 0.000$)

Table 4.3: Cultivation of cash crops in the three ethnic zones

	Idoma (n=127)	Igede (n=42)	Tiv (n=339)
Area under annual cash crops (groundnuts, soybeans, rice) *			
• none	78%	100%	20%
• < average land size	17%	-	23%
• > average land size	5%	-	57%
Area under citrus trees			
• none	88%	100%	89%
• < average land size	12%	-	9%
• > average land size	-	-	2%
Area under other tree crops*			
• none	70%	100%	98%
• < average land size	25%	-	2%
• > average land size	5%	-	-

- Statistically significant differences between the three zones exist for all variables except for cultivation of citrus trees ($p < 0.000$).

Soil fertility decline

An important problem for farmers in Benue State is the decline in quality of the soils on their farmland. Fallowing used to be the most important method to restore soil fertility, suppress weeds, and reduce the impact of *striga*.¹⁶ Only one community still had enough land available to clear new land and periodically relocate their fields. Six communities mentioned that the scarcity of land for cultivation was becoming a serious constraint. In these communities, the

¹⁵ The advantage of groundnut is that it can be harvested relatively early in the season. The income is either used to buy food—thus reducing the length of the hungry period—or it helps pay for farm operations.

¹⁶ Striga, also called witchweed, is a parasitic weed, attacking sorghum, millet, maize and cowpeas.

length of the fallow period has become too short for it to adequately restore soil fertility, resulting in considerably lower yields or even changes in the crop mixtures.

Coping with declining soil fertility without the ability to fallow requires a major shift in technology. Interviewed farmers only discussed the use of mineral fertilisers. Farmers did not mention other technologies, such as agroforestry, green manure or covercrops, as ways for improving soil fertility levels. Fertiliser used to be provided by government at subsidised prices. At present, not enough fertiliser is available in Benue State and what does arrive is either distributed through politicised channels, or can be bought at some marketplaces.¹⁷ Most farmers find it hard to acquire timely and sufficient amounts of non-adulterated fertiliser, even when they have the cash. In most of the focus groups as well as during the household interviews both male and female farmers stressed that better access to fertiliser would improve their harvests and incomes.¹⁸

Growing pressure on the land is the cause of the shorter fallow periods and lower yields. There are several sources of pressure, including population growth but also a changing rural economy: fields are expanded in response to a need for more income. Moreover, the area under orchards is expanding to diversify sources of income, but also to strengthen claims on land. In two communities, access to land had become restricted by the government for use by the army, the university or reserved for residential development (but which are not always utilised). In addition, those farmers having access to land compensated for decreasing crop yields by again enlarging their fields to maintain overall production levels, but which will reduce the length of fallow periods even more. Another consequence of growing pressure on land is dispute, mentioned by four communities, and which has even led to some violent conflict in two cases. Land pressure will affect possibilities for farming for those who rely on husbands and fathers to access a field and for households which have less land. Young men may opt for migration to other rural areas or abandon farming.

Land

In most communities, land is still perceived as the property of the clan that is holding it in trust for the (male) family members. Fields are allocated by the elders to individual households and clearly demarcated. The head of the household can then allocate a plot to his wives and children. The Tiv and Idoma people are patrilineal and when a woman marries she leaves her family to live with her husband's family. Her husband will provide her with a field. Unmarried or divorced women depend on their fathers, brothers or other male relatives to offer them farmland. Neither Tiv nor Idoma widows can inherit land, but it may be left in her care on behalf of her sons. According to custom, women only have usufruct rights and are not allowed to plant trees, but we have come across some examples of women buying their own plot of land. If a widow is allowed to continue working the land of her deceased husband, she then is the custodian of her sons. In other cases, her in-laws will hold the land and other property of the deceased husband in custody for her sons.

The average cultivated area is 4.1 hectares per household in Tiv land, 2.4 hectares in Idoma land, and 2.1 hectares for Iggede households. A higher percentage of households cultivates less than 1 hectare in Idoma land (33%) and Iggede land (40%) than in Tiv land (13%), while more people in Tiv land (47%) have plots of more than 3 hectares than in Idoma land (20%) and Iggede land (17%).

Population density is on average lower in Tiv communities, which may partly explain the differences in field size. The average population density in 11 selected LGAs, excluding Makurdi, is 99 people/km² according to census data of 1992. The average population density

¹⁷ Farmers also find it difficult to judge the value of the variety of brands on sale.

¹⁸ This may be true but there may also be a bias because research teams were often perceived as working for the government, which for farmers remains the very source of fertiliser distribution. Farmers may have wanted to use this possible channel to get their message across.

in Tiv LGAs is 94, ranging from 38 to 160. For the four Idoma and Iggede LGAs, the average density is 107 ranging from 66 to 180.

A second explanation is the difference in settlement patterns. Tiv communities are more dispersed than Iggede and Idoma communities and, as a result, farmers live much closer to their fields. It is easier for Tiv people to farm large tracts of land intensively and thus produce a marketable surplus, than for Iggede and Idoma people. Dispersed settlement also makes it easier to keep livestock as there is less risk of damage to neighbours fields and home gardens.

After wives lose their husbands, they may also lose access to their land. The household survey revealed that, on average, households headed by females cultivate significantly smaller parcels of land than male households headed by males, particularly in Idoma land (Table 4.4- see also Table 4.6).

Table 4.4: Average land size under cultivation by sex of head of household, by zone

Average hectares (standard deviation)	Male headed (n=438)	Female headed (n=70)
Idoma (n=127)	2.6 (2.9)	0.8 (0.9) (n=16)
Iggede (n=42)	2.1 (2.8)	0.3 (n=1)
Tiv (n=339)	4.4 (7.3)	2.5 (2.2) (n=53)

* Land size for Tiv male headed and female headed households is significantly more than for the Idoma and Iggede male and female headed households.

Land markets

Benue State has local land markets that deal mostly in rentals, and occasionally sales in peri-urban areas or communities situated along major roads. Renting land is often the only way of gaining access to fields for those who live in towns. It is preferred over sharecropping, as the contractual arrangements are clearer and thus less prone to dispute.

It should be noted that elderly people who have land but lack labour are often renting land out or enter into sharecropping arrangements. In two communities sharecropping situations in which young people are engaged were mentioned. We have not come across such arrangements involving widows, even although some observed that they lacked the means to work the land. Most women do not own the land and therefore do not have the authority to enter into any arrangements that involve renting out the land, let alone selling it. They will have to leave the land fallow if they cannot work it and hope that, as a result, it will not be redistributed within the family.

Labour requirements and division of works by gender

Farming in Benue State is labour-intensive; most of it done by hand. Animal-pulled ploughs are non-existent, while the few tractors in Benue State are mostly used for large-scale farming. Herbicides that reduce time spent weeding, are relatively expensive and not widely available. Another constraint is that they have often been tampered with or have passed their expiry date and so will not be effective. Farmers therefore prefer the certainty of hiring labour, though expensive, over the risk of using herbicides.

A good yield not only requires access to good quality soil but also timely execution of crop maintenance operations. Less well-off households are likely to have lower yields as they often combine farm work with casual labour and usually have less resources available to invest in their farming operations.

Women work on the family fields and also tend fields of their own. Women use their produce to shoulder part of the expenditures of the household (consumption, school fees, health care, clothing). They also use the proceeds to have some resources of their own and maintain their

networks. Many women have become more independent economically over the last decade or so, by cultivating a field of her own and through other income generating work, such as agro-processing and trade.

There used to be a clear gender division of labour according to tasks and crops, but this is disappearing. Men can now be seen helping women with planting, weeding, and harvesting, while women may get involved in land preparation of their own fields. Some explanations given concerning these changes, which presumably started over a decade ago, are that men felt obliged to help women due to the growing pressure on family labour: field size has expanded, there is more weed infestation and less hired labour is used due to rising costs.¹⁹ Without more involvement of men yields would drop. An additional issue involves the fact that more children are now in school and can only work on weekends at best²⁰. Men have also begun to cultivate crops usually associated with women but for which there is a good market demand.²¹

Information and technical support

Farm management among the majority of the LGAs in Benue State is at a crossroads and communities need to make important strategic decisions concerning crop choice and cultivation practices, for which some knowledge is already available within the communities.

BNARDA (Benue State Agricultural and Rural Development Authority) is the agency responsible for agricultural extension (see Box 4.1). BNARDA used to manage a series of large projects which have all come to an end. They still have a large staff on the ground but the level of activities has dropped. Farmers credit BNARDA with introducing new varieties of cassava, maize, and soybeans, as well as methods for increasing yam production and the introduction of mineral fertiliser. Since 1994, BNARDA has no longer been involved in fertiliser distribution and other inputs, which has become the responsibility of the LGA (via the Ministry of Agriculture).

Despite BNARDA's work, access to information is still limited in Benue State. In surveys held in Benue State, only 35% of the female farmers and 50% of the male farmers reported having access to information technology. Access to agricultural inputs is even lower: 26% for female farmers and 33% for male farmers (CWIQ, 2001). Epidemiological data already show an increased incidence of mortality amongst BNARDA staff over the past 10 years. AIDS will only further deplete the human resources and thereby reduce BNARDA's effectiveness in the field even more (see Ch. 9).

Box 4.1: BNARDA's support for women farmers

A Women in Development (WID) unit was established in 1990 following the recommendations of the Federal Government in consultation with World Bank. A study requested by these organisations concluded that although women are responsible for a large part of agricultural activities and decision-making, extension messages did not reach them. Only men were trained while a 'trickling across' of information had not occurred. BNARDA uses the Training and Visit extension system, which works through 'expert farmers' as the entry point.²² The Women in Development unit, however, worked with groups of women (ranging from 10-50 women) that meet every 14 days with the BNARDA agent for a 'monthly technical review meeting'. BNARDA prepares a programme but the women can also request certain themes in the field of agricultural production, animal husbandry or agro-processing. At least one hundred groups are active at present. In 1998, the WID unit became involved in HIV/AIDS

¹⁹ Male members of a FGD noted how they'd given up part of their leisure time and spend more time working in the fields, in part to save on hired labour costs. This in turn gives them extra resources to meet their social obligations, buy a zinc roof, and even marry an extra wife. They said that working more on the farm also improves their relationship with their wives so that the latter do not feel as if they are being used as "slave labourers".

²⁰ Children are unavailable to serve as scarecrows, leading to smaller harvests of millet.

²¹ Vegetables, as well as cocoyam and cassava in Idoma land.

²² BNARDA is now also using the 'group approach' with male farmers, 15 groups of male farmers are now active

awareness in rural areas, again at the request of the Federal Government and World Bank precisely because they were in regular contact with groups of women.

4.1.3 Common pool resources

Natural resources used to be key assets for local livelihood strategies. Forests and streams were once very important for hunting, fishing, honey collecting, and the gathering of other products (firewood, oil palm, locust beans, etc.).²³ Fish and wild game were smoked and sold. However, today only three of the twelve research sites had any noticeable forest areas or well-stocked fisheries left. In the remaining communities, these reserves have been considerably depleted, although some of the poor and young still engage in hunting and gathering activities. In places where these resources are less abundant it is mostly the poorer households that rely on these resources for extra income. When firewood collection becomes more of a burden, for example, it is the poorer women and young people in particular who start collecting it to raise money by selling it.

4.1.4 Non-farm activities

Most households have diversified their livelihoods to some degree and are involved also in activities like the processing of agricultural produce, trading, or off-farm activities.²⁴ This diversity is likely to be larger than shown in table 4.1 on occupations of the heads of households, as other household members are very active in off-farm activities.

Commodity markets are common in the rural areas of Benue State. Women engage in petty trading and sell food, while men do most of the bulk trading. Women will sell their own produce. Traders seldom come directly to the communities, possibly with the exception of orange buyers. Farmers prefer larger markets visited by many traders. They usually haul their produce to the marketplaces, and the costs are higher for farmers who live in the more isolated communities (fuel and transportation costs will continue to rise as long as roads remain in a poor condition). Some farmers in the community might buy produce from colleagues, only to sell it later in the marketplace. Some farmers have stores in the markets leaving them less vulnerable to price fluctuations.

It seems that in most markets farmers are price takers and there are complaints of "cartel" practices by traders. In one community, a local organisation was set up to ensure fair marketing practices. LGA levies, however, may reduce profits considerably. In one of the communities involved in this study, local people complained about the high LGA levies at market places, which cut deep into their profits, and sometimes even resulted in fights with LGA officials.

There are more opportunities for non-farm activities in the rural townships and the bigger marketplaces for both men and women. Young people might find work in a bar or restaurant, or work for a trader. As a result, many farmers close to these townships have problems finding enough hands to cultivate their fields.

In rural areas, formal employment opportunities are rare and mostly related to LGA offices or government services (BNARDA, health, or education). Most formal employment in Benue is in the public sector consisting of 17,000 State service employees plus an additional 15,000 LGA employees (Nweze and Ojowu, 2002). A problem for households relying on salaries or pensions is the delay in their being paid out.

²³ In one community where game and fish were readily available, all households were involved in catching and smoking fish and wild game, but wealthier households could carry out these activities on a larger scale as they used better fishing gear and rifles.

²⁴ Examples of rural enterprises include palm wine tapping, beer brewing, pottery, weaving, soap making, mat and broom making, carpentry and wood carving, bricklaying, blacksmithing, tailoring and knitting, motorcycle driving; mechanic.

In more urban areas, housing becomes scarce and in this study some well-off households have emerged as landlords renting out living spaces.

4.1.5 Mobility and Migration

In Benue there is much movement of people between households. It is also a State where migration to other parts of Nigeria, both rural and urban, in an important livelihood strategy, which involves both men and women. The next table 4.5 is based on household survey data (N=508) and gives an indication of the number of people that joined or left the household as well as their reasons for joining or leaving. Children were most often joining a household, either for schooling or because they became orphaned. These are also reasons why children left households, although mentioned less frequently. Bereavement was an important reason for leaving households, and to a lesser extent for joining, and involves mostly women. Marriage and divorce are other reasons, again mostly involving women. Many people left in search of work, others joined. Intra-household conflict is another reason resulting in people leaving. Finally, illness was a reason to leave or join a household, but not that often. These movements are partly linked to localities having facilities for higher education, certain types of work and possibly medical facilities.

Table 4.5: Reasons for joining or leaving households

	Reasons for Joining		Reasons for Leaving	
	Frequency	%	Frequency	%
Illness	14	3,4%	27	8,1%
Bereaved	25	6,0%	61	18,4%
Schooling	129	30,9%	52	15,7%
Orphan	124	29,7%	36	10,8%
Conflict	31	7,4%	63	19,0%
Work	10	2,4%	51	15,4%
Marriage	10	2,4%	26	7,8%
Separated	34	8,2%	16	4,8%
Other	40	9,6%	0	0,0%
Total	417		332	

Idoma and Igede people used to regularly migrate to work on the cocoa plantations in the south. Some remained behind and now have their own plantations. This type of migration is on the decline, however. Some elders noted that young people are staying in school longer. The crisis in the cocoa sector and the replacement of hired labour with family labour in the cocoa producing areas may be other factors (Mustapha, 1999). Migration to other rural areas is still reported by leaders in seven out of the twelve communities, six mentioned migration to urban areas and only 2 rural communities claimed that there was no out-migration.

Three rural communities have accommodated refugees in the last few years. The state has witnessed a number of recent conflicts between ethnic groups (the latest in 2000) that have led to large numbers of civilian deaths and the displacement of many of its people. The peri-urban sites and larger rural communities received migrants who come to work as traders or students.

Migrating to a city is a livelihood strategy often undertaken by young people who are seeking a better life and an escape from farming. Their parents support them, hoping that remittances will eventually be received in return to improve their own livelihoods. Education, particularly secondary education, is seen as a way for securing better-paid employment, which may explain why both parents and pupils work hard to gather the necessary school fees.

Around half of the households reported receiving remittances in cash (49%) or kind (54%) from relatives. Sons, daughters or siblings who have migrated or married into another community mostly send these. There are significant differences ($p=0.03$) between the remittances (in cash or in kind) received by households headed by males (47%) or females (61%).

A remittance can be used for consumption or invested in farming or commerce, while siblings may help to pay for the education of their younger brothers and sisters too. The average amount of a remittance is reported to be decreasing. Relatives in town are saving less because of increases in unemployment and the rising cost of living. The death of the remitter may be another cause, and armed conflicts in Kaduna and Kano have also affected the livelihood of relatives and the sending of remittances.

4.2 Wealth ranking of the study population

As explained in section 2.4, in the household survey wealth was defined using three variables: asset possession, total size of cultivated land, and cash crop cultivation. Table 4.5 presents the distribution of the households over these three variables for the three ethnic zones. From this table it can be concluded that more Idoma and Igede households possess assets, mainly in the form of means of transportation²⁵. However, looking at land size cultivated and cash crop cultivation, the Tiv households cultivate larger fields and more cash crops. These resources are important when coping with the impact of illness and death, but are being used in different ways.

Differences in wealth ranking are also found between male-headed and female-headed households, with female headed households being poorer on average (see table 4.6). Forty percent of the households headed by males surveyed and 67% of the female-headed households did not own any means of transportation. There is also a higher percentage of female-headed households than male-headed households with a total land size under cultivation of less than 1 hectare and without any cash crops.

Affected and non-affected households were also compared for the wealth indicators, but no significant differences in wealth ranking were found.

Table 4.6: Wealth ranking of households in the three ethnic zones

	Idoma (n=127)	Igede (n=42)	Tiv (n=339)
Asset possession*			
• No assets	25%	17%	53%
• Bicycle	42%	29%	20%
• Motorbike	28%	43%	17%
• Car or mill	5%	12%	9%
Cultivated land size*			
• <1 ha	33%	40%	13%
• 1-2.99 ha	47%	43%	40%
• 3-4.99 ha	8%	5%	26%
• 5 ha and more	12%	12%	21%
Cash crops*			
• no cash crops	48%	100%	17%

²⁵ Zone A (Tiv land) often scored lower than the other zones, particularly regarding access to services, perhaps because many communities were located in more remote areas. The CWIQ found bicycle ownership to be lower in zone C than our study: 47% in the CWIQ and 77% in our study (CWIQ, 2001).

-
- limited number or size of land for cash crops 48% - 53%
 - larger number of size of land 4% - 30%
-

* Statistically significant differences between the three zones exist for all variables ($p < 0.000$).

Table 4.6: Wealth ranking by sex of head of household

	Male headed (n=438)	Female headed (n=70)
Asset possession*		
• No assets (n=220)	40%	67%
• Bicycle (n=134)	29%	11%
• Motorbike (n=111)	23%	13%
• Car or mill (n=43)	8%	9%
Cultivated land size*		
• < 1 ha (n=102)	17%	39%
• 1–2.99 ha (n=213)	43%	36%
• 3–4.99 ha (n=100)	20%	17%
• 5 ha or more (n=93)	20%	9%
Cash crop cultivation*		
• none	30%	43%
• limited number or size of land for cash crops	47%	46%
• larger number of size of land	23%	11%

* Statistically significant differences between male and female headed households exist for all variables ($p < 0.000$).

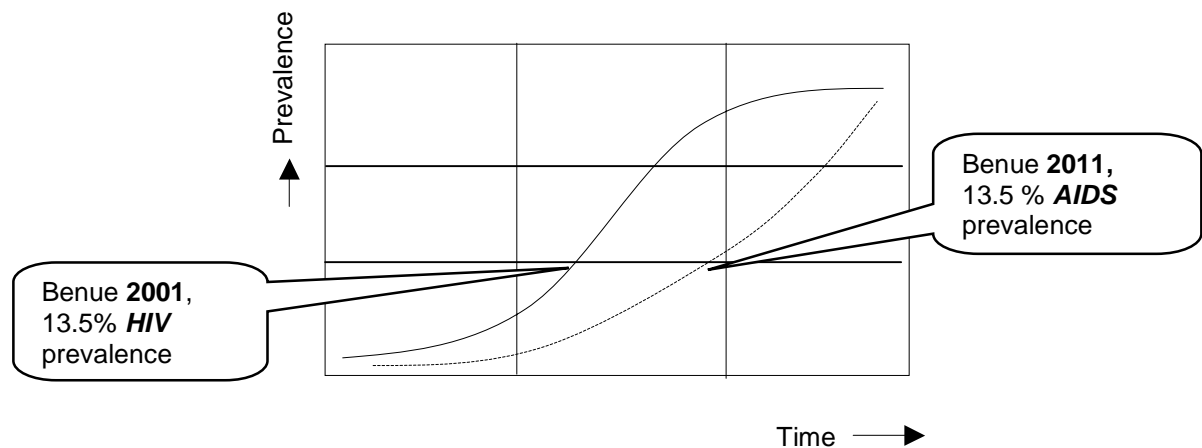
5 Epidemiology and Demography

The prevalence of HIV/AIDS in Nigeria and Benue state is analysed in this chapter. Using proxy indicators related to symptoms of the AIDS syndrome an assessment is made of AIDS prevalence in the study population.

5.1 Different Stages of the Epidemic

The HIV/AIDS epidemic can be visualised with two distinct curves: one for HIV and one for AIDS prevalence. HIV infected people are not yet feeling ill and look healthy, but they are carriers of the disease and can pass it on to others. After an incubation period of 5-10 years, the immune system eventually breaks down and they become highly susceptible to any diseases or illnesses present in their immediate surroundings (Wood et al, 2000, Stover, 2003). The length of this period depends on the type of virus (HIV-1 or HIV-2), the health condition of the infected person, the accessibility and effectiveness of treatment of opportunistic infections, various environmental factors such as access to safe water and sanitation, and sufficient accessible nutritious food supplies. The HIV infection curve thus precedes the AIDS curve by between 5 to 10 years. Because of this long incubation period, HIV infection can silently move forward in a population and does not alert communities yet to take adequate precautions to halt the spread of the infection. It is often only when AIDS deaths start to increase that preventive measures begin to be taken (Barnett and Whiteside, 2002).

Figure 5.1 below shows how both curves develop in general. The precise slope and development over time is specific for each situation depending on the factors mentioned above. The important point to make here is that an HIV prevalence rate of 13.5% in Benue State in 2001 will begin revealing its impact in the increased numbers of AIDS cases and deaths of up to 13.5% in 2011, in the event of general access to antiretroviral drugs not taking place²⁶. At the same time, the number of people infected with HIV will continue to rise, unless effective prevention measures are put into place.



(based on presentation by Tony Barnett)

Figure 5.1: Stages of the epidemic

²⁶ For 2003, Pharmaccess estimates that max. 10,000 people in Nigeria have access to ARV (Tanne de Goei Personal communication)

5.2 Review of Epidemiological Surveys

National level

Repeated sentinel surveys carried out among pregnant women in Nigeria showed a threefold increase in the frequency of HIV infection between 1991 and 2001, rising from 1.8% to 5.8%. A striking fact is that infection rates are higher in rural areas than in urban areas (although sentinel sites classified as “rural” tend to be “peri-urban” in reality). The specific prevalence rates of antenatal clinic attendees were highest for the 25–29 age group (6.3%) followed by the 20–24 age group (6.0%), and the 15–19 age group (5.9%) (Federal Ministry of Health, 2001a). The report indicates that the 5.8% prevalence rates are probably an underestimation of the actual figures and there is no evidence that the epidemic has begun to plateau. New infections in young adults are likely to increase.

Factors that contribute to the progression of the epidemic in Nigeria include: early age of first sexual activity; poverty; inferior status of women; migrant labour; commercial sex work; high rates of sexually transmitted infections (STI); and, low availability and acceptance of condoms. Furthermore, HIV-1, which spreads faster than HIV-2, is Nigeria’s most prevalent HIV subtype, representing 97.5% of total prevalence (Federal Ministry of Health, 2001a).

Though the results of the 2001 sentinel survey reveal that the country as a whole has only barely crossed the line of 5% adult HIV prevalence, the average figures mask significant regional variations (ranging between 0.5% to 21%) and very high prevalence rates among groups in a situation of risk, such as commercial sex workers.

The estimated incidence of TB in Nigeria is nearly 300,000 cases of all forms annually, ranking it as the 5th highest TB burden country in the world. Recorded HIV prevalence among TB patients rose from 2.2% to 17% between 1991 and 2000 (Technical report PTB-STI patients, 2001). Again, there is a large variation between the States ranging from 4.2% in Oyo to 35.1% in Benue State. With over 3.3 million adults infected by HIV in Nigeria, it can be concluded that when using a conservative TB infection rate of 35%, approximately 1 million adults have both HIV and TB. Such double-infected people develop TB at a rate of about 5% per year — slower at the beginning of the epidemic, but then accelerating as immuno-suppression worsens. Nigeria can thus expect an additional burden of some 50,000 TB cases annually from among those already infected with HIV.

State level

In the 1999 and 2001 national antenatal HIV seroprevalence survey, Benue State recorded the highest state prevalence rates in both 1999 and 2001: 16.8% in 1999 and 13.5% in 2001. The higher prevalence rate in 1999 of 16.8% is thought to be either an overestimation due to mistakes in the methodology or due to the large variation around the mean in the relatively small samples. When comparing the confidence intervals of the Makurdi site for both years, they tend to overlap²⁷.

Table 5.1 summarises the evolution of the HIV epidemic among women seeking antenatal care in Benue State between 1991 and 2001; Table 5.2 presents the HIV prevalence for three sites in Benue in 2001 and Table 5.3 for age groups in the North-Central Zone, which includes Benue State, again in 2001.

Table 5.1 HIV prevalence by year amongst pregnant women attending antenatal care clinics in Benue State from 1991-2001

	1991	1993	1995	1999	2001
Benue	1.6	4.7	6.7	16.8	13.5

²⁷ 1999: 95% confidence interval: 9.1-17.0 and 2001:10.9-18.9 even though the mean is quite different

Source: Technical report Sentinel Survey among Pregnant Women attending Antenatal clinics, 2001

Table 5.2 Summary of results of HIV Prevalence, amongst pregnant women attending antenatal care clinics in Benue State, 2001

	Site status	Site sample	% HIV (95% CI)	N
Benue	Makurdi	Urban	14.4 (10.6-18.9)	299
	Otukpo	Urban	11.0 (7.7-15.1)	300
	Ihugh	Rural	15.0 (11.2-19.6)	300
Total			13.5 (11.2-15.9)	899

Source: Technical report Sentinel Survey among Pregnant Women attending Antenatal clinics, 2001

Table 5.3 Results of HIV Prevalence by age group, amongst pregnant women attending antenatal care clinics in the North central zone (including Benue State), 2001

Age group	% HIV (95% CI)
15-19	9.5
20-24	8.9
25-29	9.5
30-34	7.5
35-39	7.9
Average	8.4

The highest age-specific prevalence in the North-Central Zone was 9.5% among the 15–19 age group and the 25–29 age group. Other prevalence levels: age group 20-24 (8.9%), 30-34 (7.5%) and 35-49 (7.9%). These data indicate that Benue State is more susceptible to HIV infection than most other States in Nigeria. Some possible explanations are circular migration patterns involving most of the youngsters in Idoma land but also many Tiv, liberal attitude to girls working as sex-workers in cities in order to earn money for getting married or to support their families, long distance truck roads which pass through Benue state, with Makurdi being one of the resting places, and relatively many Tiv and Idoma men who join the army.

Interviews with hospital staff indicate that the impact of the disease on the health system is already being felt in terms of workload, lack of adequate training in management of the disease and lack of drugs. In one hospital in Makurdi, 22.4% of the total admissions over the period of January to June 2001 were due to HIV/AIDS. Bed occupancy, financial and human resource input related to HIV/AIDS may reach 40-50% because persons living with AIDS remain hospitalised for longer periods than other patients and ultimately require more care (personal communication, Dr. Raj).

5.3 Analyses of Proxy Indicators for AIDS collected during the Domicile Listing

A quick domicile listing was conducted at the start of the study to guide the selection of study sites. This listing was carried out in 24 communities to obtain information on the numbers of chronically ill people, recent adult deaths and orphans in each of the households at this site (see Chapter 2).

The domicile listing reported on a total of 4478 households in which 26,269 people live (average household size is 5.9). Chronically ill household members (550 between 20–45 years of age) were noted in 1058 households and 2186 had reported deaths over the past five years, of which 805 were adult deaths between ages 20–45.

Twenty-nine percent of the households fostered one or more orphans. Although the percentage of households with orphans is available for all sites, the exact number of orphans per household is only valid for 10 of the 24 communities²⁸). Here 1242 orphans were reported by 415 of the 1570 households (26% of the households fostered on average 3 orphans). This means that orphans constitute 11% of the total population of these 10 communities in the household listing. A study on the estimated number of orphans in Nigeria concluded that orphans comprised some 4% of the total population in 2000 and this is expected to increase to 11% by 2005 (the level found in the household listing), and 16% by 2010 (Ssenigozi and Moreland, 2001).

No information was gathered at this stage on possible HIV/AIDS-related causes of illness and death. The data of the domicile listing have only been used to come to a final site selection.

5.4 Chronic Illness and Mortality: Trends over time in household survey

Of the 508 households participating in the household survey, 30 households reported a chronically ill person (CIP), there was only one chronically ill person at the time. An adult death in the past 5 years was experienced by 75 households, and several of these households indicated that they had experienced more than one death in this period. Five households confirmed that they have a CIP at home and had experienced a recent adult death. In total 106 deaths have been reported.

Fourteen percent of the study households were headed by women, which is only slightly higher than the 10% reported by the CWIQ (2001). The proportion of female-headed households was 15% for households affected by chronic illness or death. Some characteristics of the study population are presented in Table 5.4

Table 5.4: Characteristics of study households

	Idoma (n=127) 25%	Igede (n=42) 8%	Tiv (n=339) 67%	Total n=508
Households with CIP or recent death	44% (55)	14% (1)	11% (38)	20% (100)
Households without CIP or recent death	56% (72)	86% (41)	89% (301)	80% (408)
% of female headed households	13% (15)	2% (1)	16% (54)	14% (70)
Age of head of household* Year (<i>standard deviation</i>)	48 (16)	40 (10)	45 (16)	46 (16)

* The three ethnic groups in the household study population show statistically significant differences for all variables in the table, except for percentage of female-headed households.

It was found that 44% of the Idoma households, 14% of the Igede households and 11% of the Tiv households were affected by illness or death. Although the recall period for this question only referred to the past five years, the increasing trend of mortality in this study population is apparent both for the Tiv and the Idoma local government areas, but more pronounced in the latter (see figure 5.2 below). Because of the small numbers of Igede households having experienced death or chronic illness, these have been grouped with the Idoma households in the figure.

²⁸ The question was misinterpreted in the other 14 communities.

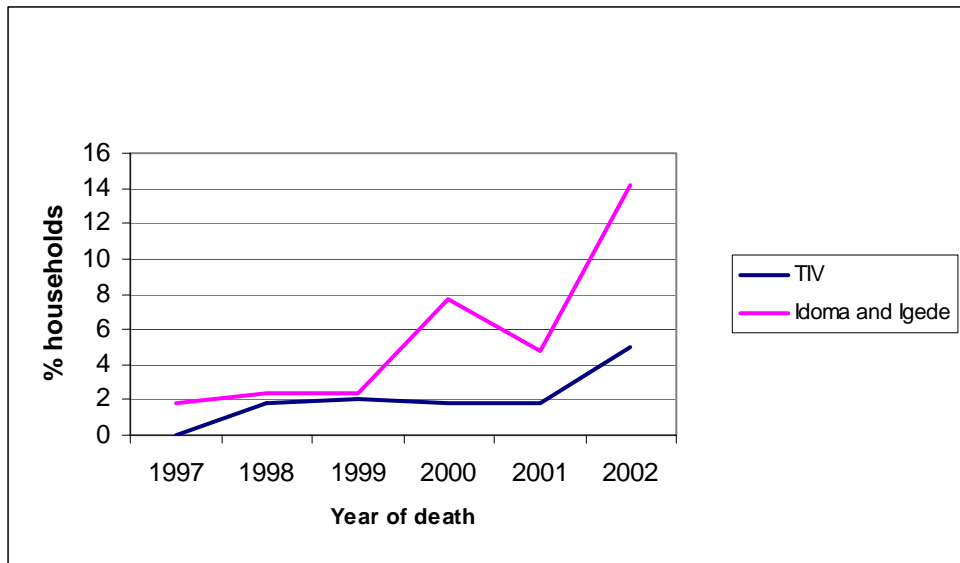


Figure 5.2: Households that have lost a person by zone and by year

5.5 Household Survey: The number of orphan events over time

Each household was asked to report the number of orphans (18 years and younger), the year the child was orphaned, the relationship of each orphan to the head of the household, whether he or she is a one- or two-parent orphan, and where they lived prior to becoming an orphan. The orphan count can be obtained by plotting the number of orphan events per year (Figure 3.4). Figure 5.3 shows that for the 508 households in the study the orphan count has exploded since the beginning of the 1990s, when the AIDS epidemic was in its infancy.

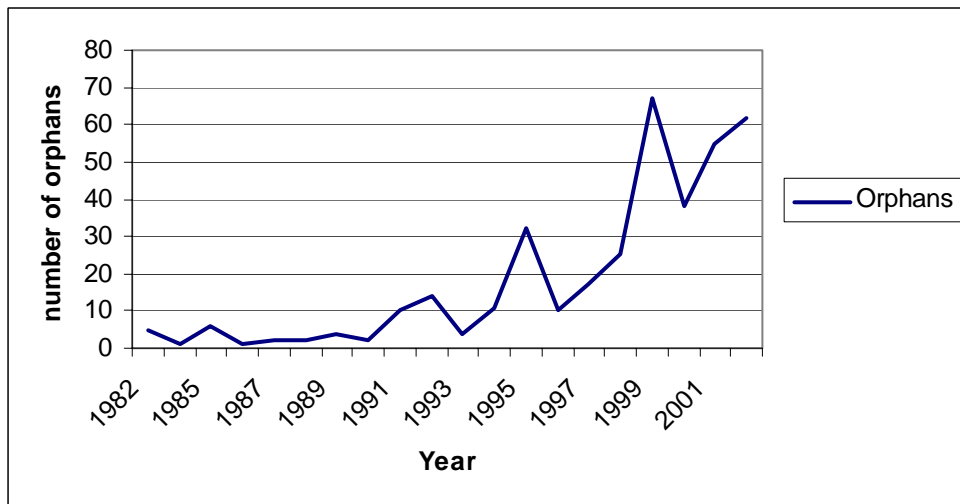


Figure 5.3: Number of orphan events per year

Thirty-four percent of all the households in the study reported having orphans, varying from 7 to 63% of the households between the 12 communities. A total of 374 orphans lived in 169 households; an average of 2.2 orphans per household of which 57% are boys. Orphans move between households, and 33% (N=124) of the reported orphans joined over the last 2 years. These households reported that another 52 orphans have left during this period. One third (34%) of the households with orphans had experienced chronic illness and death, which is significantly more than households without orphans (13%) (p=0.000).

Eighty-nine percent of the orphans are one-parent orphans, of which, in 75% of the cases it was the father who passed away. Among the one-parent orphans, relationship to the head of the household was as follows: son or daughter (21%), nieces or nephews (40%), grandchildren (10%) and 28% was related in some other way to the head of the household.

5.6 Are chronic Illness and Death Related to HIV/AIDS?

Symptoms related to the AIDS syndrome include chronic cough or tuberculosis, chronic diarrhoea, severe weight loss and emaciation, shingles (Herpes Zoster), and of course confirmed HIV infection. Sometimes, these symptoms are blamed on witchcraft. However, for the purpose of this analysis, witchcraft and poison were not classified as AIDS related symptoms.

The causes of chronic illness and death were analysed for 135 cases of illness and death living in 99 households²⁹. For 46 persons (34 %) HIV/AIDS was either mentioned directly or at least two AIDS-related symptoms were reported (see table 5.5). A total of 8% of these households (3 Tiv and 5 Idoma) had experienced multiple cases of HIV/AIDS related CIP and death over the last 5 years.

The group of households mentioning either HIV/AIDS directly or at least two AIDS syndrome related causes corresponds to 29% of all 99 households experiencing illness and death of adults, and 6% of the total number of 508 households.

Table 5.5: Relationship of chronic illness and death with HIV/AIDS-related causes

	% of chronically ill or deceased persons (n=135)
Declared HIV/AIDS	19%
Probably HIV/AIDS (2 symptoms or more)	15%
Possibly HIV/AIDS (1 symptom)	21%
Definitely not HIV/AIDS	10%
Don't know / other	36%

This study has taken a cautious approach towards the classification of causes reported for CIP/death of adults identified in this study as probably HIV/AIDS-related. When applying a less conservative definition by also including those with one HIV/AIDS symptom, 52% of the total households experiencing chronic illness or death are now classified as HIV/AIDS-affected. The category "Don't know / other" in this table includes 6 deaths and 5 chronically ill people whose conditions were blamed on witchcraft, a well-known euphemism for HIV/AIDS and other stigmatised diseases. Some of these illness and death might have been AIDS related but were not reported as such, either willingly or unwillingly. For instance, one of the study sites in the "low AIDS" LGAs reported 0% of AIDS-affected households, but at the same time registered fairly high percentages of households with CIP or death (17%) and households with orphans (31%).

If we included cases with one HIV/AIDS symptom, it would add another 11% to the percentage of HIV/AIDS-related illness or death.³⁰ Thus, a conservative classification of the levels of those affected by HIV/AIDS indicates that 6% of the total number of households in the study are HIV/AIDS affected, whereas a less conservative method would produce an additional 5%, or 2% when we include witchcraft as one of the HIV/AIDS symptoms.

Table 5.4 showed that 44% of the Idoma households, 14% of the Igede households and 11% of the Tiv households were affected by illness or death. Further analysis indicate that 33% of the 55 Idoma households with CIP/death are probably AIDS affected versus 26% of the 38 Tiv households and only 1 Igede household (or 17% of a total of 6 households with CIP/death). This

²⁹ For 1 deceased person the information on the cause of death was not available.

³⁰ At certain sites we expected a possible increase in deaths because of recent armed conflicts. However, among the 131 cases of death and illness, trauma or accidents were mentioned only 10 times, in 7 different LGAs, and not clustered in the LGA where the conflict took place.

difference between ethnic groups is not statistically significant. However, the proportions of households affected by chronic illness or death were not similar for the three ethnic groups. Forty-four (44) percent of the 127 Idoma households were affected by chronic illness or death while only 11% and 14% of the 339 Tiv households and the 42 Igede households were affected. The slight overrepresentation of Idoma households in the study population cannot explain the large difference found here between Idoma and the other two ethnic groups. In this study, households in Idoma land are significantly more affected by chronic illness or death of adults but not by HIV/AIDS (see Chapter 2.3.2).

The study found a considerable variation between the LGA study sites. Table 5.6 presents the absolute and relative figures for chronic illness, death, orphans, and levels of AIDS-affectedness for the 12 study sites. Using the percentage of AIDS-affected households, the study sites have been categorised into low, average, and high suspected levels of HIV/AIDS prevalence. All communities located in Idoma land are found in the group with a high level of HIV/AIDS affectedness. The peri-urban sites are in the groups with medium and high levels of HIV/AIDS affectedness, and not only in the 'high' as may have been expected.

Even although for the low HIV/AIDS group no affected household were identified during the household survey, in two of the communities village leaders mentioned that there have been such cases. These are communities where out-migration was not frequent and then mostly to other rural areas of Nigeria. In none of these four communities land disputes were reported by village leaders, while this was the case for all four communities in the 'average' group. In the group with high HIV/AIDS affected communities only one community experienced land disputes, in the second farming was no longer taking place while village leaders reported that there was enough land available in the two remaining communities.

Table 5.6: Chronic illness, death and level of HIV/AIDS affectedness by locality

Local Government Area	Number CIP	Number death	% Households with CIP / death	% Households with orphans	No. AIDS-affected households (% of survey households in this LGA)
Low HIV/AIDS					
1.	0	2	5%	29%	0
2.	2	0	5%	7%	0
3.	2	6	17%	31%	0
4.	0	2	5%	12%	0
Average HIV/AIDS					
5.	1	5	14%	26%	1 (2%)
6.	0	4	10%	34%	2 (5%)
7.	1	5	9%	30%	2 (5%)
8.	3	6	21%	42%	2 (5%)
High HIV/AIDS					
9.	1	20	19%	40%	4 (9%) *
10.	7	16	43%	54%	5 (12%)
11.	9	13	48%	63%	6 (14%)
12.	4	24	42%	38%	7 (16%)
TOTAL	30	106	20%	34%	29 (6%)

Within the group of chronically ill and deceased persons, 61% of the AIDS-affected and 39% of the non-AIDS-affected cases are women. When these figures are classified as they are in Table 3.6 (low, average and high AIDS prevalence), the percentage of female CIPs and deaths is significantly greater in the high AIDS LGAs than in the low AIDS LGAs. This percentage equals 10% for LGAs with low, 30.4% for average and 52.9% for high AIDS prevalence LGAs (Chi2 =8.629, p=0.013).

The focus of the study was on people between 15-49 years who belong by definition to the productive age group. The average age of the 30 chronically ill people was 34 (SD=10) and 29 for the 106 recently deceased (SD=9). Although not significantly different, the AIDS-affected men are older than the AIDS-affected women, while the non-AIDS affected men are younger than the non-AIDS affected women (Table 3.7). These differences correspond to the general development of the AIDS epidemic, with young women being more susceptible to HIV/AIDS, both physically and socially.

Most of the persons ill and deceased were contributing to household livelihood activities or supported their family while they lived elsewhere. Over 70% of them cared for up to 4 other individuals. These include their children, spouses but also siblings or parents.

Forty percent of the CIPs were taken care of in a different household to the one in which s/he lived before. Twenty-three percent of the CIPs returned from an urban area to a rural household (migrants), 10% lived in the same community but in another household and 7% came from another rural community. This information is not known about the deceased, however.

Table 5.7 shows that the ill or deceased persons were mostly first-line relatives — either son/daughter or brother/sister, though more daughters than sons, but more brothers than sisters. Very few ill or deceased reported being the head of the household.³¹ Most of these affected households are probably dissolved with widows either remarrying or returning to their parents, and orphans, in the case of illness or the death of a female head, being taken in by relatives. It should be noted that the death of an in-law or other relative that did not occur in the interviewed household will not have been mentioned.

The proportion of categories of primary occupation represented in the group of ill and deceased persons is very different from that of the total study population where 85% of the heads of households were primarily farmers, 4% were small merchants, and 8% were civil servants. Only 30-40% of the ill and deceased people had farming as their main occupation. Many were traders, civil servants or pursuing other occupations.

There are no statistically significant differences between the HIV/AIDS-affected and the non-HIV/AIDS affected in wealth ranking according to the three variables used: asset possession, cultivated land size and cash crops (see Chapter 2). Although the data are not shown here, the same holds true for the affected (all causes) and non-affected households: there are no differences in wealth ranking between the groups.

Table 5.7: Characteristics of AIDS-affected and non-AIDS affected individuals and their households

	AIDS-affected	Non-AIDS affected
At individual level	n=43	n=92
Age in years (SD)	29 (8)	30 (10)
• Men	30 (7)	29 (10)
• Women	28 (8)	32 (10)
Number of dependents (SD)	2.4 (2.3)	3.5 (3.7)
Sex *		
• Female	61.5%	39%
• Male	39.5%	61%
Zone		
• Idoma	56%	52%
• Igede	2%	6%
• Tiv	42%	42%
Relationship to head of household *		

³¹ This is consistent with finding by Yamano and Jayne (2004).

<ul style="list-style-type: none"> • Husband • Wife • Son • Daughter • Brother • Sister • In-laws • Other 	2% 5% 2% 21% 19% 21% 14% 15%	4% 12% 23% 12% 29% 9% 4% 7%
Primary occupation <ul style="list-style-type: none"> • Farming • Craftsmen • Petty trade • Big business • Civil servant • Other 	29% - 34% - 16% 21%	42% 1% 15% 1% 20% 21%
At household level	n=29	n=70
Asset possession <ul style="list-style-type: none"> • No means of transportation • Only a bicycle • Motorbike • Car and/or grain mill 	24% 45% 21% 10%	39% 27% 29% 6%
Cultivated land size <ul style="list-style-type: none"> • <1 ha • 1-2.99 ha • 3-4.99 ha • 5 ha and more 	17% 55% 21% 7%	24% 34% 19% 23%
Cash crops <ul style="list-style-type: none"> • no cash crops • limited number or size of land for cash crops • larger number or size of land 	41% 52% 7%	33% 47% 20%

* AIDS-affected individuals are significantly different ($p < 0.05$) from non-AIDS affected individuals for variables with a *

5.7 Demographic Impact

The overall structure of a population will change once the impact of HIV/AIDS takes effect. More deaths will occur in the productive age group, which will lead to fewer births because women of reproductive age are dying. HIV infected women also have a lower rate of conception. In addition, more infants and children will end up dying as a result of mother-to-child transmission (MTCT). As a result, the population structure may change from a normal pyramid to one in which there is a significant decrease in the number of adults in the productive age group.

Heaton and Stanecki (2003) studied the effects of the AIDS epidemic on national population figures in South Africa, but did not find any clear-cut evidence of demographic impact on the nation's age and sex structures. However they did recommend that the analyses be repeated at the local level by comparing an area experiencing a severe epidemic with an area having a relatively lower level of HIV/AIDS prevalence.

Therefore, for our demographic study, we selected two sites of the four classified as "low AIDS" prevalence (0%) and two sites of the four classified as "high AIDS" prevalence (12% and 16%). The two "low AIDS" prevalence sites are both in Tiv land, while the two "high AIDS" prevalence

sites are in Idoma land and in Tiv land. A complete demographic census was carried out at these sites, including the sex and age of all household members, and *de facto* household members, such as children at a boarding school, for instance, but excludes those who have actually left the community.

The two “low AIDS” sites had a total population of 918, with equal numbers of males and females (459). The two “high AIDS” sites had a total population of 1826, with 887 men and 939 women. We acknowledge that these are rather small populations from which to obtain a smooth population pyramid, as each deviation of a normal pyramid will be more pronounced. However, we believe that the method has its value to confirm our classifications made with the proxy AIDS indicators.

Bar charts (half of a population pyramid) for the “high” and “low AIDS” sites, were compared for both sexes (figure 4). The male and female population pyramids for the “low AIDS” prevalence sites appear to be smoother than those for the “high AIDS” prevalence sites.

The “high AIDS” prevalence sites appear to have gaps in the youngest age group of 0–4 years (both sexes) and for women between 30 and 55 years of age. For the men, this gap commences at age 40 and continues on into old age. Other factors, in addition to AIDS-related illnesses and death, probably help explain the population structure. Cultural and economic factors, such as more out-migration, or poorer health services and fewer economic opportunities because of geographic isolation might influence the disease and mortality patterns of a particular population.

Nevertheless, the population pyramids for both men and women within the low prevalence sites show striking similarities, which is also the case within the high prevalence sites. The differences suggest that the impact on the demographic structure of these communities is large enough and consistent for both sexes. Increased mortality as a result of AIDS might be one of the causes. The smaller base (0-4 years) could be due to a combination of increased mortality rates as a cause of Mother-To-Child-Transmission, reduced fertility figures because of HIV infection and the death of potential parents. The gap in the productive age group is apparent at an earlier age for women than for men, which also fits the general epidemic trend for AIDS.

This change in population structure can potentially also explain why one does not see dramatic changes in the dependency ratio³² in the presence of an AIDS epidemic (Stover and Way 1998). The ratio can be expected to increase due to AIDS because of the increased number of deaths among productive adults, However, AIDS increases childhood deaths as well as reducing the number of childbirths. These two trends may cancel each other out.

5.8 Concluding Remarks

Data collected on demographic change in Benue state as well as proxy indicators for the spread of AIDS all indicate the same trend: more deaths and more orphans since the beginning of the 1990s.

Proxy indicators show that 34% of **cases** of chronic illness and death are probably linked to the HIV/AIDS epidemic. These HIV/AIDS infected persons live in 29% of **households** affected by illness and death of adults.

The level of HIV/AIDS affectedness is probably even underestimated. Households mentioning only one AIDS-related symptom, or witchcraft, or those who do not know the cause of death are classified in the non-AIDS affected group. Some of these illness and death might have been AIDS related but were not reported as such, either willingly or unwillingly.

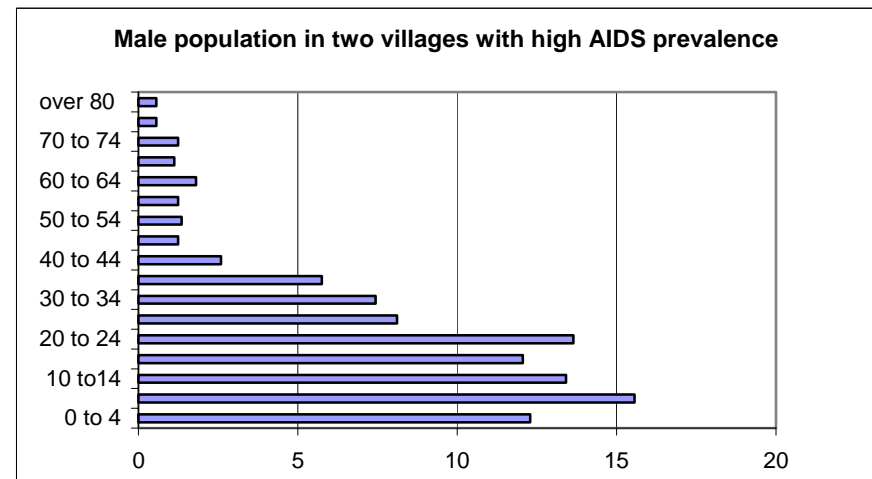
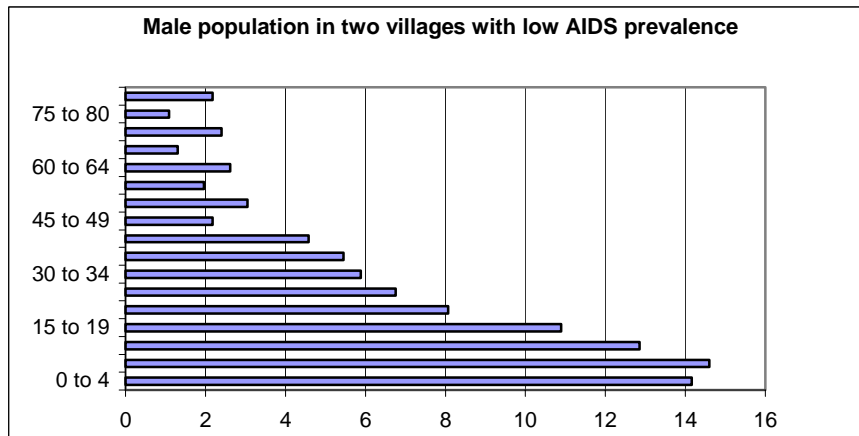
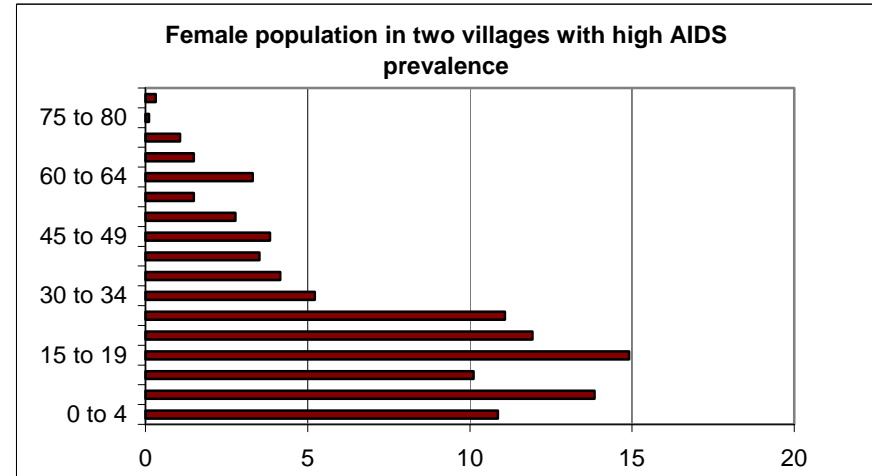
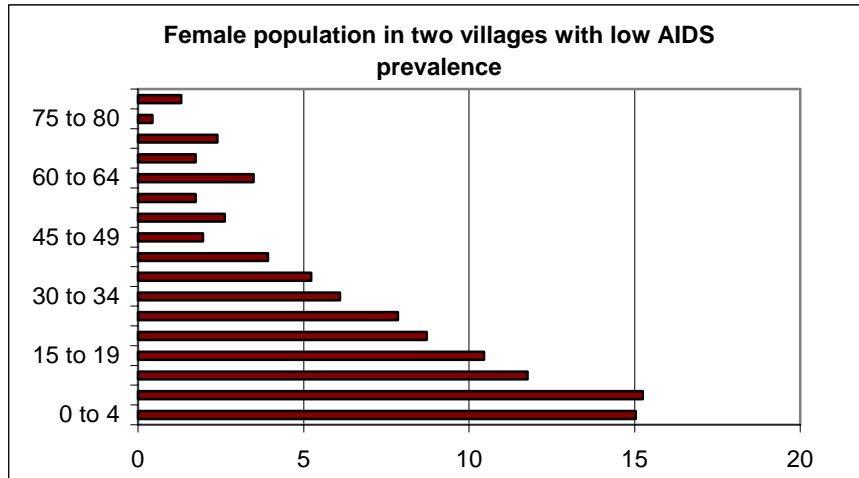
³² The dependency ratio is the number of dependents (under age 15 and over 64) per adult of productive age.

HIV/AIDS is affecting households of all wealth categories. The analyses of wealth-related characteristics shows that there are no differences in poverty (or wealth) levels between affected and non-affected households. There is also not such a difference between households affected by HIV/AIDS or by other causes.

Livelihoods of persons infected by AIDS, who on average are 29 years old, are significantly different from those of heads of households. PLWHA are more often traders or working as civil servants than farmers. Most PLWHA were not heading a household, but they do have on average 2.4 dependents.

In the study sites, 60% of the AIDS-affected are women as opposed to 39% of those who are chronically ill or deceased as a result of another disease. This explains partly the differences in the relationship with the head of the household (more ill and deceased daughters and sisters in the AIDS-affected households).

Figure 5.4: Male and female population of sites with suspected high and low AIDS prevalence



6 Responding to Chronic Illness and Death and the Implications for Livelihood Strategies

In this chapter, the effect of illness and death of adults on livelihoods is being analysed and compared with results from other studies. The effects on a community resemble ripples around affected households, determined by the type of social relationships. First, the direct consequences of chronic illness and death in terms of extra costs will be discussed. Next, overall coping patterns of households are analysed and related to ways in which the asset base of households is put to use. The third step explores the difference in responses between subgroups and makes comparisons between ethnic groups and across wealth groups.

6.1 Being affected

Households are affected when they have a chronically ill household member, or a household member who recently died. Affected households deal not only with the psychological stress as a result of chronic illness and death of beloved ones, but also with the costs in terms of labour and expenditures for medical care and burial. In addition, they will have to forego production and income because the PLWHA, as well as the caregivers, can no longer attend to their usual activities.

Other households become indirectly affected because they have assisted and aided a member of an AIDS-affected household in times of illness and death, but the boundary is not always clear-cut (see box 6.1). Ill persons may move from one household to another for four reasons: 1) to spread the financial burden within a family 2) to avoid the financial burden by a forced move³³; 3) to facilitate medical care, for instance to be closer to a hospital or traditional healer; and, 4) to avoid rejection, even looking actively for anonymity³⁴. Data collected on people joining or leaving the study households found that 3% (N=14) of this group left because of illness, while 8% (N=27) joined study households for this reason (see table 4.5).

Households become also affected when they take in orphans or contribute to their care. Thirty-four percent (34%) of the study households have taken in orphans (although we do not know how many of them are AIDS orphans). During fieldwork several people interviewed reported paying the school fees of orphans living with other relatives.

In conclusion, there are probably very few households in communities or extended families where people are living with HIV/AIDS that are not affected.

Box 6.1: Affectedness: a dynamic process

The head of a relatively better-off household described how his divorced sister, who was living in Abuja, returned ill to the community and stayed in his house. He took her to hospital while another sister came to care for her. When it was clear to them that their sister was not going to survive, they brought her to their father's place where she died soon after.

In the process, the brother had spent all his savings on medical expenses and funeral costs. There was no money left to hire labour for his farm and his wives therefore had to do much more work in the fields, for which he felt sorry. He was so strapped for cash that when the

³³ The cases we have come across are sending back ill people by family-in-laws to one's own family. For example, a married woman, who is initially taken care of by the husband, may be sent back to her parents or siblings when she becomes very ill.

³⁴ We have not come across this situation in the fieldwork, but informants from Makurdi spoke about relatives who had AIDS and then chose to stay with a relation far away from their hometown, insisting that nobody should know about their status.

roof blew off he even had to ask for a loan for the repair. He also withdrew from social functions because he lacked money.

One of his wives was also interviewed. She was not complaining about the workload and only expressed relief because her sister-in-law had left their household just in time and had not died at their place. Paying for the funeral costs would have had even more of an impact on their livelihood.

(Individual interview PRA study Benue State)

6.2 Coping or surviving

It is important to realise that although the term 'coping' suggests that a household can actually manage, this is often not the case. Even when households seemingly cope, the long-term costs are actually undermining their livelihoods (Rugalema, 1999). Although in this study the term 'coping' is used for households dealing with a difficult situation, it can be misleading. Coping suggests a positive outcome whereas some households or individuals do not actually 'cope' but instead have to make difficult choices, lose assets and barely manage to make ends meet. Box 6.2 illustrates a typical case scenario of an AIDS widow trying to get by without the support of her in-laws but is actually no longer coping.

Coping does not consist of isolated actions but of "many actions taken as an integral part of the rural livelihood system" (Campbell, 1990). Non-erosive strategies are those that reversible and do not result in permanent damage to a household's livelihood. Erosive strategies on the other hand are those that deplete assets in an unsustainable manner or to such a degree that the household's resilience to future shocks is weakened permanently (SADC-FANR, 2003). Erosion occurs when households, having exhausted other strategies, are forced to undermine their livelihood strategies risking poverty and food insecurity.

There is a sequence in the use of so-called coping strategies, generally corresponding to an increased use of so-called erosive strategies which will have an increasingly long-term impact on livelihood strategies and result in irreversible changes to the asset base (Corbett 1988, Mbaya 2002, Drimie 2002).

Box 6.2: Coping or surviving?

A 32-year-old widow recently lost her husband, most likely due to AIDS. She has 6 children, aged from 1 to 18 years, but the eldest three now stay with her brother. About a year ago this family was regarded as being of 'average wealth'.

Her husband was only seriously sick for a short period. He was in and out of hospital for four months while also having herbal treatment in between. Every time his resources were finished he came home, until he or his wife managed to find additional cash. They raised money by selling stored harvest as well as a piece of land. One brother also gave money.

In the fifth month of his illness the doctor proposed an HIV test. Her husband must have concluded that there was no more hope and refused the test, preferring not to spend more money on his health at the expense of his household. He died only a few weeks later. The funeral was paid for with the help of his brothers while the women's association provided chairs for the ceremony and moral support.

His widow had to care for him during the illness and, as a result, she could not attend to her fields. The yield was very low. She was not disinherited and is still farming her husband's fields, but her father-in-law is controlling the households' expenditures. The household has become food insecure and she was not able to pay her children's school fees. She expressed a feeling of desperation when thinking of her household's future.

(Individual interview PRA study Benue State)

6.3 Direct Costs of Chronic Illness and Death

6.3.1 Loss of labour

Family labour for farming and other activities is reduced in all affected households. The ill person can no longer work while other family members have to provide care. In cases where the ill person dies, a funeral has to be organised and paid for. Funerals and burials generally demand a lot of organisation such as preparing the funeral place, preparing food and drinks, receiving and entertaining visitors. The mourning period also restricts activities. Close relatives cannot attend to their normal activities and feel depressed. Affected households will have to forego production and income because the PLWHA, as well as the caregivers, can no longer attend to their usual activities. Moreover, psychological stress as a result of chronic illness and death of beloved ones will affect productivity.

In the household survey, 66% of the affected households reported that they had lost the income of the ill or deceased person, 87% told about loss of some other type of contribution made by this person, whereas 58% of the households reported that they had lost also income and contributions provided by the caregiver.

Ill people will try to do as much work as possible and for as long as they can until they are completely bed-ridden. People living with AIDS may have felt unwell for many months while continuing their work, although working maybe less hours or less intensively.

Caregivers spend time accompanying him or her to medical appointments, bring food, search for herbs or run errands, and provide other support when they are hospitalised. The amount of time that the male head of the household, his wife and a boy or girl child would spend on a set of activities was analysed comparing affected and non-affected households, as well as comparing between those affected by AIDS or by illness and death caused by another disease (Table 5.1).

Table 6.1: Average number of hours spent on care per week

	With chronic illness and death	Without illness and death
Male head of household	12 (16) *	4 (5)
Female household member	14 (16)*	6 (5)
Boy child	10 (5)*	4 (4)
Girl child	11 (7)	5 (3)
Average	12.1	4.8

* Significant difference between time spent by members of household with a chronic illness and death and without ($p < 0.05$)

This analysis shows the significant difference in time spend on care by all household members when living with an ill person, including the men and boys ($p < 0.05$)³⁵. Women spent on average 14 hours per week, men 12 hours and boys and girls 10 and 11 hours per week. When comparing the time spent on care between AIDS affected and non AIDS affected households (but with CIP) the female household member and the boy child spent significantly

³⁵ Only the data for the girl child were not significantly different, probably because of the small number of cases in that group.

more time on care in the AIDS affected households than in the non AIDS affected (resp 18 vs 12 hours per week for women en 16 versus 7 hours for boys. For men the difference was not significant and for girls there were insufficient cases to analyse.

Table 5.1 shows further that men, women, boys and girls provide weekly a few hours of care to other affected households.

Caring for a patient and arranging funerals is thus time-consuming and labour intensive. Households will try to maintain their livelihood activities, household chores, child care etc. during this event. However, when the work is no longer done properly or not at all, household chores, crops, trading and business suffer³⁶. Small businesses suffered because opening hours were more erratic and irregular and jobs were not finished on time. Family members of ill people and in particular caregivers often reported feeling overburdened. In interviews they spoke of not being able to concentrate on looking after the farm or their business. Most caregivers lacked time and could not attend their own field(s) adequately. Some young people reported that they could not attend to their own income-generating activities because they had to take care of an ill person.

6.3.2 Time spent in mourning and funerals

Upon the death of the ill person, relatives respect certain funeral and mourning rituals affecting their daily routine. In Idoma land, during the mourning period, the entire household is expected to stay at home, and all social and economic activities come to a standstill. During interviews, various people mentioned that their crop was spoiled as a result of mourning restrictions. These rituals impact not only on livelihood activities but also community activities, as people have no time to attend the meetings of their associations, or to meet with extension workers or others. Funerals and mourning rites are time-consuming. Rituals vary between ethnic groups and among communities. Within communities they differ in length and restrictions for widowers, widows, family members and other villagers. The duration of the mourning period depends on the mourner's relation to the deceased and is decided by the head of the household. A close relative, for example, may have to stay at home for two weeks while a more distant family member will only mourn for 7 days, and neighbours 1 to 3 days only.

Table 6.2 shows how many days were spent over the past 12 months on attending funerals and mourning for men and women in different groups of households. Women mourn over longer periods than men, while also facing more restrictions for their daily routine and movements. Compared to the Tiv, the Idoma spent more time at funerals and both Idoma and Igede people also spent considerably more time in mourning. In some of the Idoma communities length of mourning is already less than what it used to be when a period of 3 years was required for widows and widowers. None of the community leaders mentioned the relaxing of restrictions or a mourning period because of an increasing number of funerals.

Table 6.2: Average number of days attending funerals or spent in confinement over the last 12 months

	Funeral		Mourning	
	Men	Women	Men	Women
With chronic illness/death (n=100)	16 (18)	14 (16)	38 (55)	43 (68)
Without CIP/death (n=408)	11 (12)	10 (11)	16 (27)	21 (39)

³⁶ Reasons given were lack of working capital, distressed, not enough time and concentration, losing clients because service provision became too erratic. Activities mentioned were trading, food hotel, shoemaking; traditional healing.

Idoma (n=127)	19 (19)	18 (18)	41 (49)	49 (54)
Igede (n=42)	8 (6)	8 (5)	25 (49)	49 (94)
Tiv (n=339)	10 (11)	9 (9)	12 (22)	13 (28)

* All comparisons between groups of households with or without CIP or death, or between households from Idoma land and Tiv land, are statistically significant at $p < 0.05$. Standard deviation between brackets.

6.3.3 Responding to labour constraints

Illness and death have always been part of life and households have developed ways of dealing with its consequences. Households reported various ways of coping with a decline in family labour availability. Forty-five percent of all affected households reported that they hired others to do the work in the fields; 29% of the households reported that they had reduced the area under cultivation; and 4% of the households reported changes in crop mix (from yam to cassava). Moreover, 62% of the affected households received support in the form of field labour from their families.

In order to cope with lack of labour, affected Tiv households reported significantly more often than affected Idoma households that they hired labour; respectively, 76% and 24%. With regard to reducing the area under cultivation, the Tiv reported land size reduction 4 times more than the Idoma households (respectively, 8% and 2%), but this difference was not statistically significant.

Social networks can provide help and 25% of the affected households reported having received this kind of support. The Tiv and Idoma also differ when it comes to contributions from others, with the Tiv receiving significantly more support from community groups (51%) and friends (38%) than the Idoma (15% for both community groups and friends). However, the labour may not always arrive in time and the work is not always well done.

Overall, significantly more households with a larger area of land under cultivation reported the use of hired labour to deal with labour losses within their households than those with less land (70% and 32% respectively).

Finally, some households (10%) had members who had to start working as casual labourers to raise some immediate income or food, resulting in less time available for their usual activities, such as their farms.

There is a labour market in all of the studied communities, commonly involving casual labourers and labour groups. Those who can afford it will hire labour³⁷. Significantly more affected households (90%) reported hiring labour than non-affected households (75%) ($p < 0.001$). Hiring labour requires resources that are not available to every household. Twenty-three percent of the affected households reported that they had reduced the amount of hired labour as compared to the previous year, as opposed to only 12% of the non-affected households. Some communities also reported the presence of migrant labourers during peak periods. Extra labour can also be requested through various networks (non-traded) in return for a meal and sometimes money.

Farmers often complained about the rising costs of casual labour, which have doubled over the past decade. In four communities located near urban centres, labour scarcity is considered a growing constraint on farming, because many young girls and boys prefer non-agricultural work. The most important changes reported by the community's youth are a declining interest in farming, especially for those attending school who entertain the hope of getting a well-paid job. Some boys are turning to non-agricultural jobs because they look down on farming. As some said: "farmers are poor, dirty and never eat well because they sell

³⁷ For weeding operations, herbicides represent one alternative but adulteration and erratic availability reduce their use.

of the best part of their harvest". Young people also prefer paid work to working for nothing in their parent's fields, which has led to a strain in the relationships with their parents.

Local labour markets in or near the community are very important for households with resources who are looking for replacement labour. They are also crucial for the survival of other households who need money urgently and have members who are strong enough to work. Particularly in the Idoma zone, some pledge labour in the next season against a loan.

6.3.4 Expenses during illness and after death

Expenses during illness

Extra expenses during illness include costs for medication, traditional healers, travel to hospital and admission fees. The average expenses on illness reported for the 6 months preceding the household survey were 29,500 Naira³⁸ ranging from N3990 to N150,000 (Table 6.3). The medical expenses over 6 months are higher for AIDS-related illness than for the other reported chronic illnesses, such as blindness or trauma, although not statistically significant. Significantly less is spent on traditional healers for AIDS related-diseases. Considering the long-term character of the disease and the fact that there is no cure available it is not surprising that the medical expenses are high for AIDS-related illness. The largest differences, though not statistically significant, are found in expenses for chemists and pharmacists.

There are no differences in overall medical expenses between men and women except for traditional healers where women spent significantly more money than men (N 6400 versus N2600, $p=0.04$). This finding could not be explored further. It should be noted that in discussions on poverty indicators, respondents stated that the poor would rely more on traditional healers, while those who can afford it would prefer treatment in hospital (see Annexe 3). This is not necessarily explaining the difference between expenditures on treatment for men and women in the household survey, as the total amount spent on treatment for women was N 8000 higher, although this is not a statistical significant difference.

Burials and funerals

In Tiv territory, over the past few decades, funerals have become more and more elaborate. The establishment of mortuaries and the availability of preservation technologies have revolutionised burial practices. Corpses can now be preserved for longer periods, for up to a year in some cases. The time of a funeral is dependent on one's family status, age of the deceased, frequency of deaths in that family, and even the season. A family with adequate resources can bury their loved one as soon as all the family members have arrived. Poorer families need more time to raise the money for the coffin, the grave, and the rites. When the burial period is prolonged, many return home to their normal lives, but close relatives have to remain available to receive condolences and entertain visitors. This period is usually physically and emotionally draining, time-consuming, and costly.

In Idoma territory, the dead are generally buried two days after death. If the deceased died of a stigmatised disease such as leprosy, the corpse may be buried at night in the bushes. Funeral ceremonies are postponed until a family has the money to arrange a funeral; the richer a family is and the higher the status of the deceased, the more money is spent.

Costs for funerals include a coffin or burial cloth; soap and clothing for the death person; digging and cementing a grave; and drinks and food for the visitors. In Tiv land, costs for the mortuary and for transporting the body come on top of this. Average funeral expenses reported by the affected households in the survey mounted to almost 20,000 Naira. Total expenditure on funerals is likely to be higher since people from other households also

³⁸ Data on expenditures for illness show a large standard variation around the mean, making it more difficult to find statistical significance differences.

contribute. These amounts can be considerable, in particular when contributing to the funeral of parents or siblings³⁹: e.g., 16,000 Naira for a coffin, a loan of 20,000 Naira, providing 400 yams having a value of about 20,000 Naira. When money is lacking, burials are sometimes kept quite simple: no coffin is bought and no extravagant invitations are sent out, while youth groups, friends and neighbours help to dig the grave.

The survey data do not provide evidence for higher funeral costs for the Tiv as compared to the Idoma. Still, many Tiv respondents thought that funeral rituals had become too expensive. Some elders consider this a serious problem (similar to the high prices for brides), but find it difficult to stem the tide. Only family heads can decide to put a stop to these practices. The Catholic Church has also entered the discussion with its verdict on the issue: the deceased should be buried within 10 days of death. The Protestants have declared that burial should take place within 2-3 weeks.

Funeral expenses did not differ significantly according to sex of the deceased person, although more money seems to be spent for women than for men (N 5000 more in total for funeral and mourning). Expenditures on funerals and in the mourning period are, however, influenced by the age of the deceased person: expenditures are significantly higher for those above 30 years of age than those below 30 years of age.

Table 6.3: Medical costs over the 6 months preceding the interview and funeral expenses for AIDS-related and not AIDS-related cases of illness and death

Type of expenses	AIDS-related		Non-AIDS related	
	Naira (SD) #		Naira (SD)	
Traditional healer *	2410 (3059)	(n=36)	5238 (11036)	(n=82)
Health clinic/hospital	20156 (30717)	(n=36)	14347 (35519)	(n=82)
Chemist/Pharmacist	11723 (46126)	(n=36)	3229 (8717)	(n=82)
Transport to clinic/healer	3226 (2926)	(n=36)	3118 (4984)	(n=82)
Other expenses for illness *	0	(n=7)	1541 (3260)	(n=22)
Mourning (food, etc)	8459 (13733)	(n=29)	9930 (11904)	(n=60)
Funeral (coffin, etc)	8266 (6692)	(n=29)	8307 (8253)	(n=60)
Obligations to in-laws	1429 (1952)	(n=28)	2373 (6669)	(n=60)
Other costs related to the funeral	310 (1339)	(n=29)	476 (1778)	(n=59)
Total medical costs	37514 (70738)	(n=36)	26346 (41940)	(n=82)
Total funeral costs	18608 (17862)	(n=28)	20165 (17307)	(n=59)

* Significant difference between the subpopulations of AIDS-related and non-AIDS related illness or death

SD – standard deviation. A large SD indicates a large variation around the mean.

Box 6.3: Putting expenses in context

In order to appreciate the importance of the amounts of cash involved, a comparison with several average income levels or expenses is insightful. An average of N30,000 in medical costs is the equivalent of more than 5 months salary for a government employee (minimum wage of N5500/month⁴⁰) or a season's profit for a small farmer selling surplus production (400 yams). Strong young men will need to work more than 85 days while making yam heaps (N350 a day plus a meal) or spend 150 days weeding (N200/day for men and women alike).

³⁹ In Tiv land, the first daughter is expected to provide the coffin for her mother and father. Parents will bury their children or they may request support from one of the siblings.

⁴⁰ The exchange rate in 2002 was about N130 for 1 USD

An average family of 6 persons can feed itself for three months on this money (5 yams for N350 daily), but it is also sufficient to buy 10 bags of fertiliser (farm gate price over N3000⁴¹.)

(Personal communication Florence Abeda)

6.4 Coping with extra expenditure

Households are used to having to raise extra cash needed to cover expenditures as a result of illness and death. This cash is often needed quickly and may entail relatively large sums. Table 6.4 gives an overview of how study households affected by AIDS or other chronic diseases paid for the costs of health expenditure and funerals. The table indicates the percentage of households using a strategy, but these do not say anything about the size of the actual contribution.

The AIDS-affected and non-AIDS affected households do not differ in their ways of responding to expenses incurred during illness or which are otherwise related to death. Although medical expenses seem⁴² higher for households living with AIDS, they have not yet been forced, at this point in the epidemic, to resort to more erosive strategies than those used by non-AIDS affected households. It seems that the inroads of AIDS are only recent in these communities and few households have yet experienced multiple cases within a short period of time.

The strategies that are used most frequently in our study are a combination of: contributions from other people; loans; selling farm produce; the sale of seeds and yam sets; the sale of crops still in the field; undertaking activities to generate extra money; savings; the sale of livestock; reducing investments in farming, particularly hired labour; and using cash from salary. Few households report taking their children out of school to reduce expenditures on school fees; the sale of property; working more as a casual labourer; or, the sale of land. Some individuals or households may have to rely on certain survival strategies that are not regarded as appropriate in the community and were therefore not mentioned to enumerators, such as begging, stealing or transactional sex.

Households have no problem finding buyers for their goods but prices may be very low. Affected households may resort to distress sales, when cash is needed urgently or there is limited local demand and/or ability to pay. The prices may therefore be relatively low. It should be acknowledged that those in or near the community having easy access to cash might actually benefit when having the ability to acquire assets at relatively low prices from affected households in urgent need of cash. An increase in morbidity and mortality at household level can increase inequality at the community level. Distress sales can be reduced when there are well-functioning markets for agricultural produce, livestock and property in the vicinity, or a financial system where these goods will be accepted as collateral.

The importance of the social network is shown in the reliance on contributions from other people (in cash, kind, labour) by most of the households. Part of the loans is also obtained through relatives and friends, which eventually may become gifts, if the provider does not insist on repayment. The size of these contributions differs from situation to situation and is likely to be more important for funerals. Several people in the PRA stated, for example, that there is more help available during funerals than during the period of actual illness.

⁴¹ Pers com. Florence Abeda, BNARDA.

⁴² Difference is not statistical significant.

Table 6.4: Overview of coping strategies to pay for extra expenses

Coping strategies	All affected households
Contribution from others	87%
Took loans	75%
Sold produce	72%
Sold seeds in storage	40%
Sold crop in field	38%
Income generation	31%
Savings	25%
Sold livestock	23%
Reduced hired labour	19%
Salary	17%
Reduced school fees	12%
Sold property	10%
Casual labour	8%
Sold land	1%

Households use combinations of coping strategies which change over time. The choice of possible strategies depends, of course, on the assets at their disposal, range of livelihood activities, availability of surplus produce and other reserves. Possibilities for coping strategies are also depended on the opportunities offered by the locality where people live, e.g. availability of common lands or markets, demand for hires labour.

Poorer household with no reserves have fewer choices. Relatively well-off households may have more produce and plant material in store, more livestock, more savings or other sources of income than poorer households. Selling off part of these goods will not affect next season's farming operations and they are in a position to postpone using certain strategies that imply irreversible changes to the livelihood strategies of a household. However, even when next year's cropping season is not in danger, coping strategies will reduce their capacity to invest and spend on future projects. When those savings are meant to pay school fees, a child's future is jeopardized. Or where savings were needed for investments, such as hiring labour and other agricultural inputs, next season's farming operations will not be expanded.

Initially, ill people and their close relatives prefer to hide their difficulties from others and opt for strategies that lie within the household's means and are not visible for others. It is only when they can no longer cope on their own that they will involve outsiders in their efforts to deal with the situation.

They first make use of non-productive assets, avoiding as much as possible any erosion of their resource base (using savings, surplus produce and livestock). Also, they will try to avoid as long as possible using coping strategies that do not upset their livelihood strategies, thus not drawing upon the more essential productive assets. Trade-offs may have to be made between a household's maintenance of current food security and consumption levels and its protection of future income generating capacities. The coping strategies used may reduce the asset base and impede on livelihood strategies, leaving a household and individuals more vulnerable to new shocks.

The following sequence was suggested in discussion with research assistants:

1. Sell livestock; sell farm produce and processed food; use savings
2. Sell cassava crop still in the field; request a loan in return for the pledge to work in future; Ask for support or a loan from relatives; raise extra money through agro-processing
3. Sell or mortgage household property;

4. Close *bam* account; ask for an earlier turn in the pay-out cycle from *adashi*
5. Take children out of school so that they can go out and work
6. Lease out land; sell motorbike
7. Give young girls away in (early) marriage

6.5 Diversity in coping based on ethnic or wealth differences

6.5.1 Differences in coping strategies between Idoma and Tiv areas

Livelihood activities in Tiv and Idoma land differ and this influences their responses to illness and death⁴³. On average, Tiv people cultivate larger fields than the Idoma and keep more livestock. The Idoma own more assets in the form of motorbikes and bicycles than the Tiv, enabling activities such as service delivery and trading (see table 4.1).

When analysing the ways in which the Tiv and the Idoma pay for the extra medical and funeral expenses, the following can be noted: In Tiv land, households reported a greater use of savings, use of salary, sale of livestock and planting material, or reducing expenditure on hired labour than in Idoma land (Figure 6.1).

Several explanations are given for these differences between the Tiv and the Idoma. In this study, more Tiv heads of households have a salaried job than in the Idoma zone (see table 4.1), which explains the use of salary. The Tiv keep more livestock (CWIQ, 2001) and therefore have more animals for sale when required in times of emergency. The Tiv also farm on a larger scale than the Idoma and therefore probably have a higher income from farming, more surplus produce and more seeds to sell.

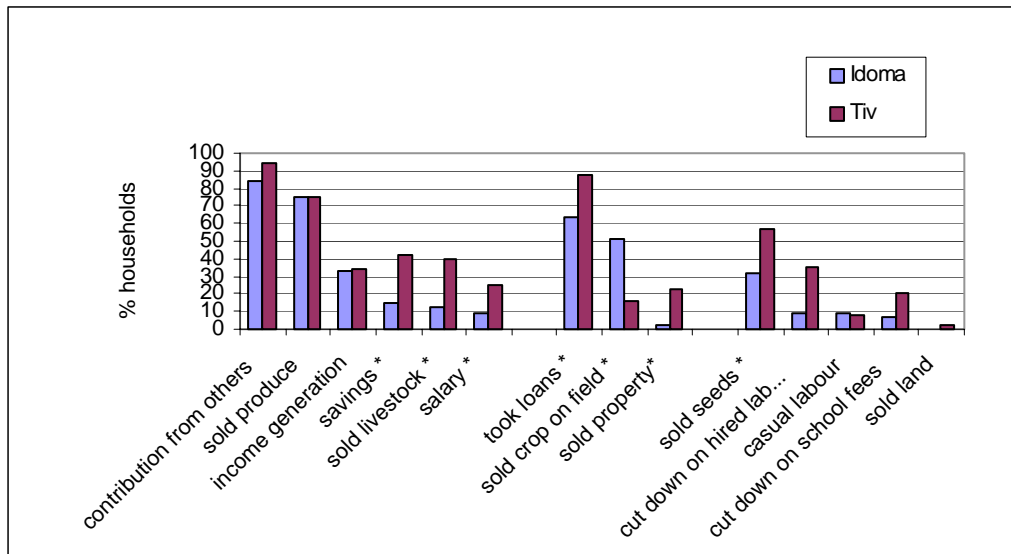
The Idoma people more frequently reported the sale of crops still in the field, notably cassava, than the Tiv⁴⁴. Both Idoma and Tiv people grow cassava, but here the explanation seems more cultural. Tiv people see themselves as farmers and will first sell property before selling crops in the field, while the Idoma people are less reluctant to sell non-harvested crops⁴⁵.

One possible explanation for the higher number of Tiv households that cut back on paying school fees is that education is more highly valued in Idoma land than in Tiv land. This is corroborated by the state level statistics on access and school enrolment (CWIQ, 2001).

⁴³ The Igede households will not be included in this analysis since there were only 6 affected households identified - too few to draw any valid conclusions.

⁴⁴ Mature cassava can be kept in the ground for storage for some time

⁴⁵ Pers. Com. Florence Abeda.



* statistically significant differences between Idoma and Tiv households

Figure 6.1: How do Idoma and Tiv households pay for medical and funeral expenses

6.5.2 Differences in coping according to wealth and gender

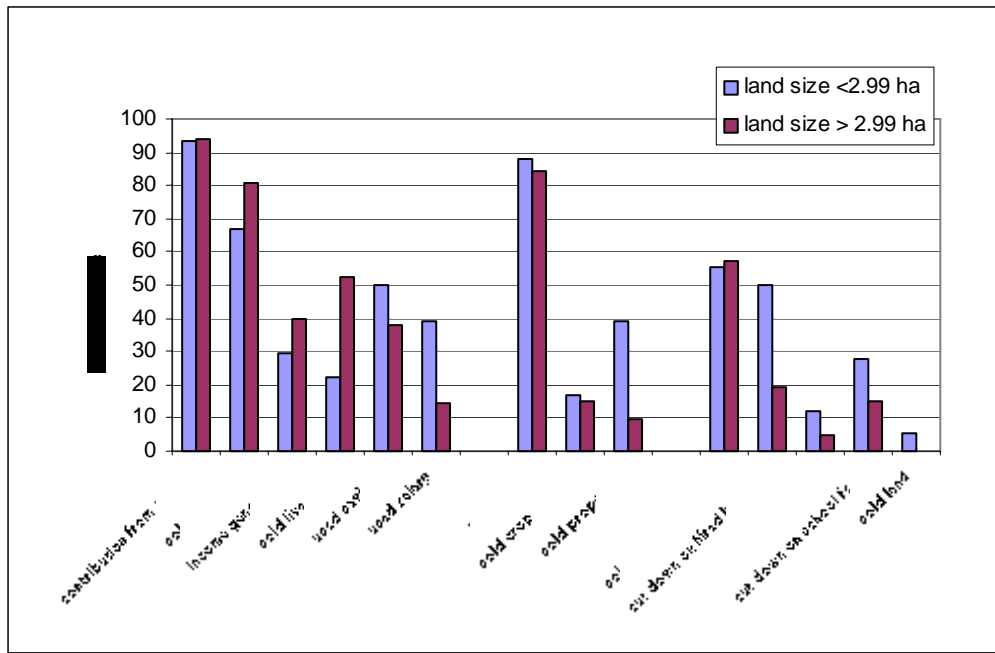
In this section we analyse whether the use of coping strategies differs across wealth categories within the two ethnic groups. The indicators used to define wealth are total land area under cultivation, cultivation of cash crops and asset possession (see section 2.4 for more detail on choice and definition of indicators).

Significant differences⁴⁶ between affected male headed and female headed household were found only for selling produce (more by male headed) and selling property which was more done by female headed households. Female headed households have less land and therefore less surplus to sell. The property sold includes kitchen utensils.

Figures 6.2 and 6.3 show the coping patterns of Tiv and Idoma households ranked according to land size. It is assumed that the households with a larger land size are supposedly better-off.⁴⁷

⁴⁶ Number of cases for affected female headed households is very small (14) versus 88 male headed households.

⁴⁷ Statistical significance is only found for few coping strategies because the numbers of the sub groups have become quite small. The total number of affected Tiv households is 39, 18 with land size less than 3 ha and 21 with 3 ha. or more. The total number of affected Idoma households is 56, of which 41 have less than 3 ha of land and 15 have 3 ha or more. 37 Idoma households have no assets or only a bicycle, 19 own a motorbike, car or a mill.



* statistically significant differences between households with land size over and under 2.99 ha.

Figure 6.2: Coping strategies of Tiv households with different land sizes

Significantly more Tiv households, who have a smaller land area, sell property and cut down on hired labour than those owning more land (Figure 6.2). Other important differences, though not statistically significant, are more sale of livestock by households with more land and more use of salary by households with less land. Presumably those with a salaried job are not fulltime farmers and work on smaller parcels of land.

No differences are found between those who were better off and the less well-off with regard to reduction of land area under cultivation, nor for changes in crop mix, or labour contributions by support groups or family.

* statistically significant differences between households with land size over and under 2.99 ha

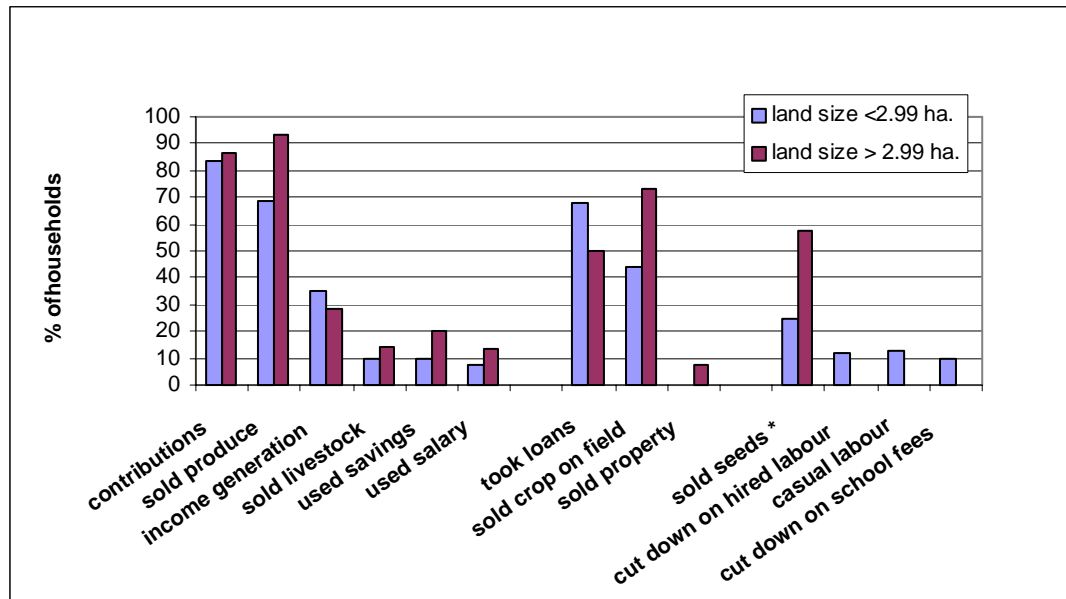


Figure 6.3: Coping strategies of Idoma households with different land sizes

For the Idoma households (Figure 6.3) the only significant difference between those with more and less land is the sale of seeds. Those with more land sell more seed or planting materials. Other differences (though not statistically significant) include more sale of produce and property by the Idoma with more land and more loan taking by those with less land. Possibly those with bigger fields produce enough to be able to sell off the surplus and planting materials and are also the ones who were able to invest in motorbikes in the first place. Those with smaller fields have to go into debt faster to pay for the extra costs.

6.6 Implications of morbidity and mortality for the asset base

In this section we will analyse the implications of illness and death of an adult on the asset base. We will discuss the effects on human capital, natural capital, physical, financial and social capital at household level.

Obviously, human capital of households is clearly affected by illness and death. The ill person can no longer work or has died while other family members have to provide care. Future human resources are threatened, when children are being taken out of school. Although children's education is of great concern to parents, affected households may have fewer resources to pay for school fees. Moreover, the ill person may have been contributing towards school fees too. In the household survey, 12 households reported reducing expenditures for education and their children are out of school⁴⁸. Another concern is the future of orphans: will they be cared for and educated as well as their parents would have done. Finally, some people seem to take human capital literally by marrying off young girls to obtain the bride price.

Natural capital includes land and other natural resources in terms of both availability and quality. Possible effects of illness and death on natural capital are less investment in soil fertility maintenance; reduced access to land through renting or sale; and, greater use of common pool resources. Renting out land is also a way of generating extra funds; a strategy, which is reported by several households in the PRA. In the household survey 10% of households mentioned renting out land as one outcome of dealing with illness and death. Only two male headed households in the PRA and one case in the household survey reported

⁴⁸ In communities with private and public schools, children may switch from one school to another depending on the parents' means.

selling land to raise extra resources for medical expenses or funerals. In the case of the PRA land was sold for building plots. No household reported increased gathering activities, fishing or hunting to raise extra funds to cope with the costs of illness or death.

Physical capital includes houses, livestock and plant material, stored produce, household goods and other property and in the study, households sold these to raise cash needed for paying expenses. A widow, for example, had sold her dishes to raise money for her late husband's treatment. Other households reported selling their motorbikes that used to provide an income as these were rented out. Households also reported not building a new house or not having the money for repairs.

Financial capital refers to the cash flow within households such as salaries, pensions, remittances, savings and loans. Those having a salary or pension will use this income for paying costs, assuming that it is paid on time, but pensioners, in particular, may wait months for their cheque. Salaries, pensions and remittances are greatly affected by chronic illness and death of the person who earns these incomes. Savings belonging to the ill person and other relatives are used to cover expenses. When these sources of cash dry up, then borrowing will be the next step, particularly to pay for funerals.

Loans are obtained from informal financial institutions, from relatives or friends. Others ask for a loan in return for their pledge to work at some point in the future; a practice, which seems more frequently used in Idoma land. People are careful not to damage their access to thrift and informal credit organisations and will default upon their obligations only as a last resort. People who are sick, especially those who are suspected of having AIDS, may not get a loan because their disease is regarded as fatal, unless another member steps in as a guarantor for repayment. If the person taking out the loan dies, then his or her relatives are expected to pay it back. Households reported needing at least several months before they could pay back all the loans taken to pay for medical costs and funerals, although some lenders will not insist on repayment. In the meantime, such households will find it difficult to invest, making it even harder to reconstitute their livelihood activities.

The role of social capital, as well as changes due to illness and death, will be explored in the next chapter.

7 Local support systems

7.1 Community Organised Support and Welfare

Community-based organisations aim to support their members experiencing hardship. Some of these organisations have a mutual fund to which everyone regularly contributes. This fund can be used by members for low or no interest loans to help pay for medical costs or funerals. Some organisations may offer material and moral support to ill members and at funerals.

All community-based organisations report that they periodically assist the “needy” in their communities with food, labour, water, and firewood. They mentioned supporting widows, the elderly, and orphans. The youth claim to be an important source of assistance to the needy: *“we support those that do not have clothes and who have nobody that can help them with firewood”*. Boys and girls each provide assistance that fits their respective gender roles in society. So the boys make yam heaps, build homes, repair roofs, and sometimes girls might assist them. Girls, on the other hand, provide care, do the washing, cooking or bring fuel wood, plant and harvest crops, or perform domestic chores. Boys do the tasks that require travelling, like transporting the sick to a hospital or a clinic.

Both boys and girls offer their assistance at the household and community levels with the understanding that it can only be offered on a short-term basis. The sick are expected to recover and repay their debts. They may also provide some financial assistance although this is commonly left to the household or extended family. In one community with a high number of CIP and deaths, some young people complained that all their earnings are regularly consumed by the current generation of needy people.

There was no mention of any significant charity work by churches, although they play a crucial role in the supply of medical services in Benue. Local efforts to raise money were more oriented towards building churches. Support by church-related organisations mostly referred to moral support and prayers, and only occasionally some financial contribution. However, church members have set up various groups on their own initiative which provide support to other members and the needy elsewhere in the community.

7.2 Support Systems for the Sick

Table 7.1 presents support received by affected households from relatives, neighbours or community associations. This figure shows that most frequently support is received from relatives. The family helps out with care, food, transportation, sustaining livelihood activities, paying for hired labour or school fees, or caring for orphans. Contribution of community organisations is mostly in the form of labour during illness and also financial support. Neighbours are only occasionally providing support, such as sharing food.

During the qualitative research, in two communities all households interviewed were asked whether they had been giving this type of support over the last 2 years. In both communities all households had contributed with food, drinks, money, labour or loans, except for one who only gave moral support because she had no money. In general, the poorest households did not contribute any cash or very little (400 Naira)⁴⁹ but they did contribute by providing food

⁴⁹ The exchange rate in 2002-2003 was about N130 for 1 USD

and small loans to friends⁵⁰. The better off not only supported relatives and friends but also gave food and money to the needy in their community.

Support to ill people seems less generalised and more erratic, although many will send from time to time some cooked food, firewood, or send their children to do chores for the affected household. Support from others, however, tends to decline when a disease becomes more chronic. Furthermore, when the condition is regarded as fatal, or suspected to be HIV/AIDS, people may be less willing to give support financially. Several respondents stated, for example, that in cases of diseases that have no cure, people sympathize but are not willing to help financially because they feel that the situation is hopeless. Then again, many people will contribute to the funeral and attend it. Contribution to funeral costs and support to the bereaved is a social obligation but reciprocity is underlined too. Some added that respecting obligations and rites is also important to avoid bad luck.

Table 7.1: Affected households receiving support for various activities

	Family	Neighbours	Community groups
Care for the ill	93%	5%	4%
Food for the ill / household	89%	11%	3%
Transportation to clinic/healer	81%	5%	4%
Field labour during illness	62%	6%	21%
Field labour after death	63%	7%	18%
Other jobs during illness	77%	8%	5%
Other jobs after death	64%	4%	10%
Financial support for medication	82%	5%	26%
Financial support for funeral	69%	7%	29%
Financial support to pay for labour	73%	2%	10%
Financial support for school fees	71%	2%	5%
Non-specified financial support	53%	3%	4%
Care for orphans	57%	-	1%

By far the strongest safety net form of social support is the extended family. Support is given mostly by the spouse, parents, children or siblings. There are social conventions that regulate how one requests and receives assistance. When one level of the social network can no longer cope, the next level is called upon for help. An ill person may first try to cover medical expenses using his/her own resources. The immediate family is looked upon for emotional support. When the ill person can no longer cope, the closest relatives (spouse, parents, children) are asked to provide material and financial assistance. Support from the community and from friends can be called upon at different stages depending on the type of assistance needed and the relationship that the person in need has with his/her community.

The first requests for further assistance go to the head of household where the ill person lives (Step 1) and will involve the husband, wife, or parents. A husband's other wives will only offer assistance upon his request, but food and assistance with the fieldwork is given readily. After that, assistance is requested of siblings with the same father and mother. It is only when all of these parts of the support network have been exhausted that the head of the extended family is called upon (Step 2). If the problem is also beyond him, he summons a meeting of extended family members. If this fails to resolve the problems, the community elders are brought in (Step 3).

⁵⁰ In addition, most households in one of these communities had supported refugees of the 2001 conflicts with food, cash, cloth and plant material

Community-based groups to which the ill person or household belongs (age groups, church fellows), friends and neighbours will be called upon around the time that the extended family is contacted. Although the sequence is the same for both the poor and the wealthy, the better-off families are generally better able to handle these problems using their own resources. Figure 7.1 below shows the relationship between the different layers of the social network.

If a community member becomes ill in another town, elders may visit the patient to decide on the type of care needed, including whether to turn to orthodox medicine or traditional healers.

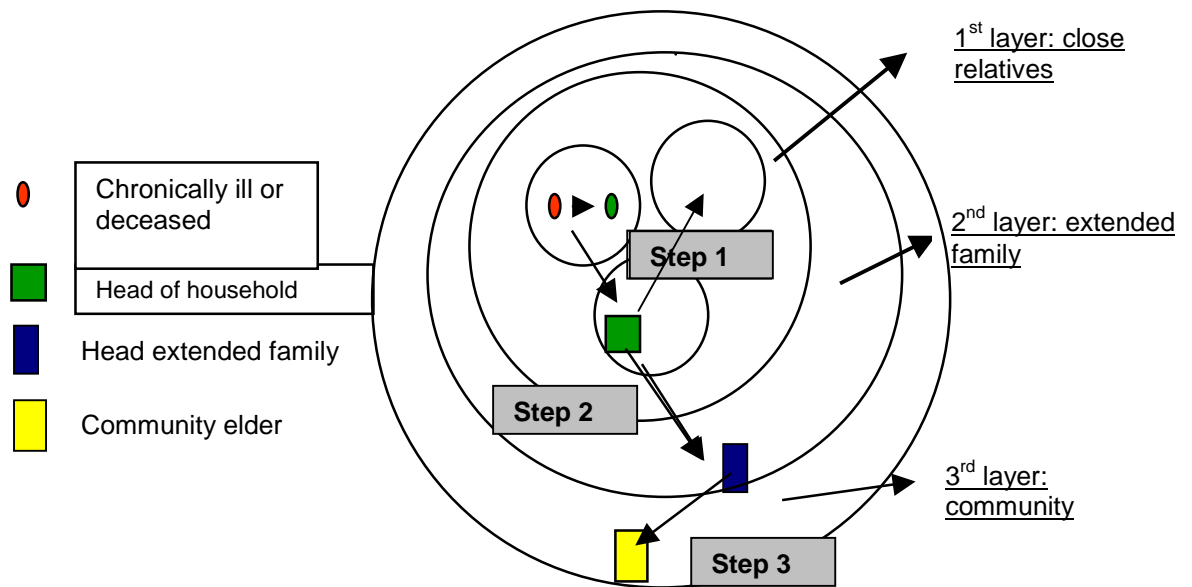


Figure 7.1: Relationships within the social network

An example of how the various levels of support are enlisted, is presented below:

The head of an extended family recalled the support received when two of his brother's sons died one after another. One had been sick for 8 months and the other for over a year. One son had the financial means to pay for his own care and although the immediate family did not help financially, they did visit him in hospital. The other could not pay for his own medical costs, so his father paid the hospital bills, while his wife took care of him. Relatives brought food and visited him in hospital. The church contributed some funds to help pay the hospital expenses. When both of them died, the extended family rallied around the father and the widows and helped arrange the funeral.

Social capital is founded on reciprocity and needs to be built up, which requires a capacity to invest cash, time and labour. Respondents were clear that those who have been contributing in the past could expect help when they needed it ('support given is like a seed sown today to be harvested later'). Poor people have more difficulty meeting these obligations and may therefore have less social capital to draw upon. As one widow said: *I don't have any money so I do not belong to any groups. I have withdrawn from social activities.* Another widow said that she did not have the money to pay the entry fee (a goat and drinks) to become member of her late husband's age group, which would have given her access to labour and other support.

Although respondents emphasised that “*There is always some kind of help*”, support has to be requested and is not given to everybody. The strength of the relationships is essential too. People who are not on good terms with relatives and neighbours will receive less support. Some expressed reluctance to assist relatives whom they regarded as lazy or “bad”. There was one example of a man, who had never been on good terms with his brothers, being ostracised when he fell ill. This neglect was extended to his widow and child after he died.

Households under long-term stress (psychological or financial), and also ill people, may start to withdraw from social networks because they are depressed, do not want to upset others, or can no longer afford to participate. Fourteen percent of all affected households in the household survey felt that illness and death have driven them into social isolation. This was significantly more so for the AIDS-affected households (27%) than for the non-AIDS affected households (9%). Households cultivating less than 3 hectares of land felt significantly more isolated (20%) from their social relations than those with a larger parcel of land under cultivation (3%). The difference between the number of Idoma households (18%) and Tiv households (8%) that reported social isolation was not statistically significant.

Support is still provided to households in need, but is reported to be on the decline. In the PRA, nobody stated that the family could no longer cope but some households were complaining that the numbers of requests were increasing fast and they were wondering if it would still be possible to continue responding positively to all of them. Others said that, regardless of the number of requests, they would help wherever they can. Availability of such ‘outside’ support to affected households depends on changes in levels of poverty, the number of requests and whether solidarity is sustained.

8 Vulnerability of households to the effects of illness and death

This section presents an overview of various determinants of vulnerability for households and of groups within households, and the effects of chronic illness and death of adults.

8.1 Vulnerability of livelihood strategies

In the wealth rankings the people interviewed were very clear on the key aspects of well-being: living space; food security; access to services; family size; health; children's education; capacity to save and borrow; size of fields and investments; availability of orchards and livestock; scale of trading; possibilities for diversification; access to remittances; and, not being depend on others. Having no access or being on the wrong side of a scale makes the household more vulnerable (see Annexe 3).

Livelihoods in some communities are more vulnerable to the impact of AIDS than others. This vulnerability is related to differences in geographical distance to urban zones or markets, allowing for more diversified livelihoods, and to differences in soil quality, rainfall and population density, affecting agricultural productivity. Culture is another determinant of vulnerability, influencing farming practices and preferences for certain livelihood activities and investments, as well as rituals related to funerals and mourning.

Other sources of vulnerability are the state of the economy and working of markets in Nigeria and Benue which determines availability of services, income and employment opportunities. Public investments in infrastructure, water, health, and education facilities are limited, resulting in poor basic service delivery. A cause for concern is that over the past decade, farming has actually become more labour-intensive per unit of harvest in Benue. Farmers have less return for their investments and may even see an actual overall decline in their harvests. This trend increases the vulnerability of households livelihood strategies in those communities where good quality land becomes scarce.

Across households, sources of vulnerability are essentially related to differences in asset base, which in turn are affected by gender and age of the head of the household. The better off have reserves, which are used to absorb the shock of illness and death, whereas the poorest are forced to use coping strategies that erode their livelihood opportunities. As we have seen in previous chapters, there are differences between the ethnic groups and between male and female-headed households with respect to resource endowments and livelihood strategies, and as a result, coping patterns differ too.

Chronic illness or death will leave most households more vulnerable afterwards, but the extent of the shock will differ. On the one hand, how much is needed? The level of expenditure in terms of cash or in kind, and labour costs differ according to the duration of the illness, season of the year in which the illness starts or when the person dies. The season in which the event occurs is especially important where farming is the main occupation. The costs of treatment, the funeral expenses, and the length of the mourning period, are also of importance.

On the other hand, how many reserves and resources are available? The capacity to cope is determined by the set of assets at the household's disposal and the resilience of its members' livelihood activities.

Figure 8.1 visualises how various types of households with different levels of vulnerability, pass through the stages of illness, death and recovery. In this process, some households will

approach the poverty line or even cross it. A similar trend was pictured by Drimie and Mullins (2002) when comparing the effect of HIV/AIDS on households with weaker, and households with stronger, safety nets.

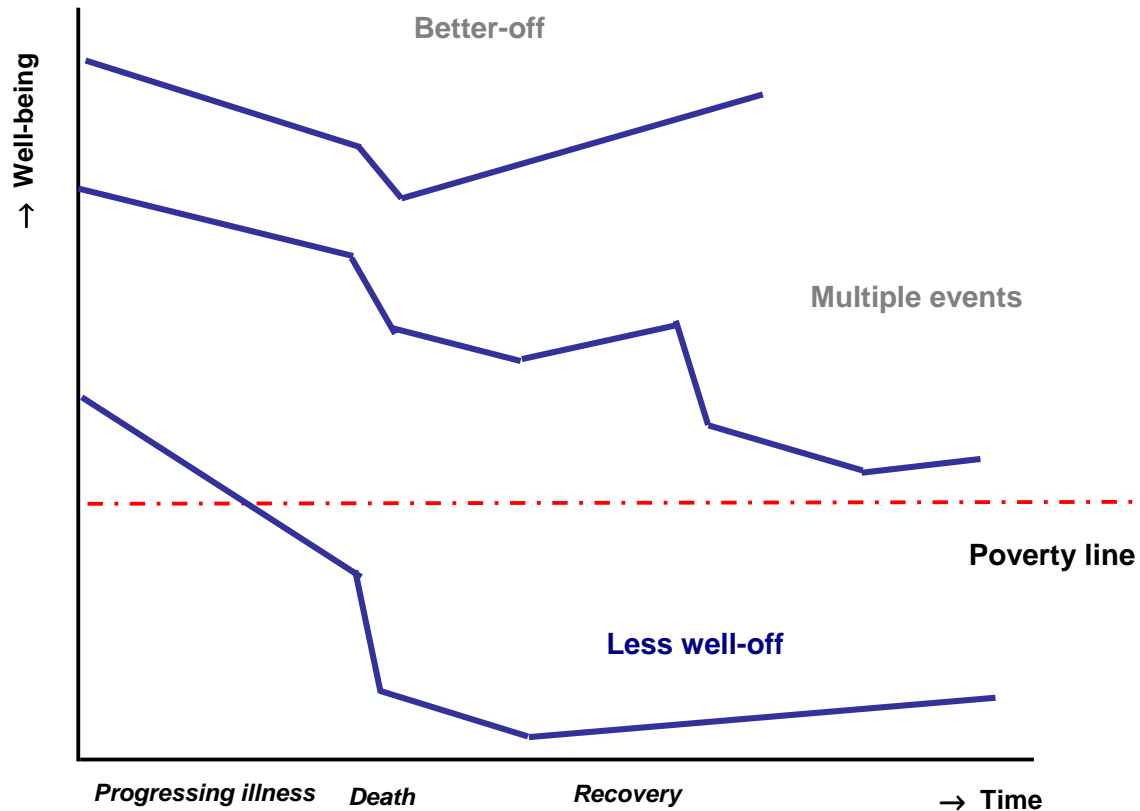


Figure 8.1: Schematisation of trends in asset-endowment in the course of the illness, according to levels of vulnerability

Multiple events of illness and death within one household over a short period of time increase vulnerability because the household is not able to recover from the first shock before the next one occurs. Box 8.1 illustrates how a rich household becomes less well-off due to multiple cases of chronic illness and death. In this study, 8% of the affected households experienced multiple cases of illness and death in the past 5 years. As indicated earlier, the number of people suffering from AIDS will double in the coming years, with more households facing multiple events of illness and death.

Box 8.1: Slipping into poverty

A thirty-seven year old carpenter had been entrusted with the responsibility for the extended family by his father, although he was not the eldest son. His father was a wealthy man with five wives and over 30 children at the time of his death. The carpenter is now responsible for feeding and caring for his siblings, irrespective of whether or not they are older or younger than himself, as well as supporting the entire family.

Over the past 5 years, he has experienced the death of 8 of his brothers, all petty traders. He believes that some of them must have died of HIV/AIDS, since their girlfriends also died shortly after or before them. Only two of his brothers had children and after their death, the orphans were shared amongst the family.

As a result, the carpenter’s household has been indebted to quite a number of *bam* and

adashi organizations and has since been trying to pay back these loans. The size of the farm was reduced too, because there was no money to employ farm labourers or buy seeds for planting. In his own work, the carpenter has not been able to complete people's orders on time, because he was either at the hospital to visit a sick relation or burying a relation. Although the customers sympathise they also want their work done and he has lost orders. To recover from all these problems, he relies on his wife to get loans from *bam* and *adashi* to start selling grains, vegetables and fried fish, while he will try to win his lost customers back.

The death of 8 members of the family has reduced their hope that one day, one of them would have become a wealthy person and then support the entire family. Moreover, the families of their wives are worried about the large number of deaths and started threatening to call their daughters back home since they did not want them to become widows as well.

(Individual interview PRA study Benue State)

Which households are forced to erode their resource base? Table 6.3 indicates that around one fifth of the households are taking an advance on future earnings and production capacity by reducing their investment in farming (19% reduced expenses on hired labour), stopping the payment of school fees (12%), starting to work as a casual labourer at the expense of their own farms (8%) or selling land (only one household).

Possibly, the higher expenses for medical costs and funerals reported by these households forced them to use erosive strategies. Their average expenses on illness were about 25% higher than for the total affected group: 37,315 Naira, and the funeral costs too were a little higher: 22,500 Naira. They are all farming but the area cultivated is below the average. They belong to the poorer households in the community: 7 out of 12 (58%) did not own any means of transportation. The wealth ranking as measured in the study, however, can also be the result of erosive coping and households might have ranked as better-off before the events of illness and death.

Table 8.1 proposes a general household classification according to the level of vulnerability. This classification could be more refined by taken into account which member of the household fell ill and what role he or she plays in livelihood activities. The strategies available to the households for coping with the consequences of illness and death, and the effects these coping strategies may have on their livelihoods both determine the level of vulnerability of a household. A household's resource base is, in this case, both a determinant of coping as well as the outcome of coping.

Table 8.1: General classification of households according to vulnerability of illness and death

Type of household	Ways of coping with expenditures	Effects on livelihoods	Vulnerability level
Well-off, with reserves	Postpone expenditures and investments; Use part of savings; other income, pensions	- No direct effect on consumption levels and continuing expenditure on livelihood activities. -Cannot invest to improve livelihoods or consume more -Less capacity to support others	Depended on who died, and his/her role in income generation and production
Well-off, limited financial reserves	- Sale of some livestock; - Use of all savings; - Sale of reserves (produce, plant material;	- All reserves are used; - No direct effect on consumption levels and continuing expenditure on livelihood activities.	Vulnerability to shocks increases
Average. Average sized farm not very diversified livelihood	- Reducing consumption; - Borrowing; seeks help from support network; - Oversell stocks and seeds; - Raising extra money (agro-processing)	- Part of future income is already 'spent';	Temporary no capacity for saving
Less well-off, still farming but low yield	- Selling or pledging labour - Reduce investment in farming and business	- Less food and income from farming and business; - Shift to other livelihood strategies requiring limited capital and giving immediate results - Irreversible erosion of assets	Livelihood affected, but still productive
Poor Includes poor FHH and elderly people without support	- Reduce school fees - Increased reliance on casual labour, - Farming declines - Lease or sell land - Gathering and handouts - Dependent; (early marriages)	- Structural reduction in farm production; - Reduction in future human capital development - Change in livelihood strategies,	Dependent on safety net and local welfare

8.2 Orphans, Widows and the Elderly

According to the communities, vulnerable sub-groups are widows, orphans and elderly with no more support. This vulnerability starts off with bereavement, although not all widows and orphans will become impoverished as a result. About 70% of the ill and deceased persons took care of at least one dependent. When he or she dies, the dependents are left behind and need to be taken care of. This study, focussing on heads of households, expected to find an increase in households headed by widows, grandparents or even orphans. This was, however, not the case in Benue State.

The percentage of female headed households is similar among affected and non-affected households. Few households composed of only elderly people and young children were found. Two households were headed by orphaned young people, one a boy of 20 and another boy of 18, who had lost his mother a year earlier and was responsible for 4 younger siblings. The conclusion is that many of these bereaved do not form their own households but seem to be living with another household. Differences exist in access to productive resources, income and food within households. Not everybody is equal.

According to the household survey, 10% of the orphans are being looked after by their grandparents. Interviews revealed that looking after young grandchildren is a great burden for the elderly, but an orphan over 15 is regarded as an asset. Instead of having a more quiet life and being looked after, they now had to continue farming or other work to raise sufficient money to take care of the orphans.

8.2.1 Tiv Widowhood

When a man dies, his extended family takes full responsibility for the funeral arrangements. Tiv widows are not obligated to buy special goods as they are in Idoma territory and widows no longer have to grieve indoors.

In Tiv land, it is the duty of the family of the deceased male to look after his widow and children. A brother of the deceased traditionally married the widow and adopted her children (widow inheritance). This tradition still continues but has become much less important⁵¹. Reasons that have been reported include the spread of Christianity, which preaches monogamous relationships, brothers who shun their traditional responsibilities, and the brother's wives or the widows themselves may also voice their objections to the arrangement. This change may have been accelerated by the spread of the HIV/AIDS epidemic.

Widows expect to be inherited 'partially' at least, meaning that the husband's brother provides material support. Many widows complained, however, that they receive limited support from their in-laws, despite the brother's traditional responsibilities. This was confirmed by some elders *"most women, especially those with children, are now left to manage their husband's assets. But this leaves widows to shoulder every responsibility by themselves such as paying school fees, medical bills, and so forth"*. Poverty following the death of the husband is the source of a lot of anxiety to widows. As a result, they are unable to cope and look after their children properly. The change to 'partial inheritance' offers many widows more independence to manage their own lives, but it may also weaken her and her children's relations with their in-laws.

Even when a widow is not inherited and is heading her own household, her husband's brothers or father may insist on taking key decisions relating to property and the future of her

⁵¹ One estimate is that one third of the widows in Tiv land are still inherited.

children. For example, one widow spoke about her in-laws interference in her children's future:

"The difficulty I have is the fact that my brothers-in-law want my daughters who are at puberty age to be given in marriage, after which they can collect the bride price and share. My resistance has caused my children and I a lot of problems. It has led to the confiscation of my husband's pension, which I should use to pay for the children's schooling. As a result, my elder son who is in his senior secondary school cannot register for his qualifying examination now, and has to drop out of school".

8.2.2 Idoma Widowhood

When a man dies, the widow and her family are obligated to feed the immediate family and guests for 3 days before she receives any assistance from her in-laws. Widows are also required to provide a wrapper, burial cloth, mats, soap, gunpowder, and a goat for the burial. These charges may mean exhausting her savings, taking out a loan or seeking the assistance of relatives. A widower also has to buy clothes for the deceased and entertain the mourners.

Rules and restrictions for mourning are more severe for women than men. The mourning period for a widow in Idoma land might last for several months, when she shouldn't be seen outside her home during the daytime. During this period she also cannot engage in any economic activities. Mourning periods that coincide with crucial agricultural periods may adversely affect the harvest of plants that scatter their seeds, such as sesame and soybean, or which start to germinate when harvested too late (groundnut). Many women rely on relatives to do the farming or pay to have it done. The widow's parents and friends should provide for her and her children but this does not always happen and may lead to impoverishment as a widow explains:⁵²

Once you become a widow, you have to stay indoors for three months and during that period all your farm produce may rot away. If you have money or good relatives, you may get some help with the farm work, but this is seldom offered.

Widows on Idoma land also used to be "inherited" by the brother of the deceased husband, but this is no longer obligatory. Elders in one community noted that only a well-mannered widow would be inherited, and elaborated on the advantages for that woman: she then could stay in the community, continue to care for her children and even have more. However, if it is suspected that her husband died of AIDS or another contagious disease (leprosy) she will probably not be inherited. *"The husband will receive a normal burial but nobody will go near the wife"*.

The eldest brother inherits the husband's property. However, some families have decided not to dispossess the widow and leave the property to her eldest child. Overall, many widows in the Idoma communities seem not to be given custody over land and property and are left alone to fend for themselves and their children. In most cases, widows end up returning to their own families.

As one widow observed:

"One is deprived of one's husband's property including his personal effects like clothes and bedclothes. In my case, they went to my farm and dug up the yams during the mourning period. The brothers' wives are unfriendly to us. They call us witches and insult us".

One widow told of how *"even the bed was taken by my husband's brother"*. She had to take her children and leave the house. She now works as a casual labourer in return for food and some cash. The children remain in school but their house is in poor condition.

⁵² There are reports that the rites are changing. The mourning period used to be 3 years but has gradually been reduced to 3 months.

It seems that in Idoma society widows are more often accused of having caused the death of her husband than in Tiv society. In such situations, the widow's in-laws will not help her — she is effectively shunned. Her children may be taken away from her and she may end up being sent back to her own relatives. When AIDS is suspected to be the cause of death, the woman is often accused by the husband's relatives of having infected her husband. When a woman develops the signs of AIDS before her husband does, she will be considered the source of the infection. A widower is seldom accused of having caused his wife's death.

8.2.3 Widowerhood

Widowers receive more support than widows. A widower is usually well taken care of by relatives, who make sure he does not feel lonely and isolated. A widower also tends to have more sources of income than a widow, and often has more than one wife as well. In polygamous situations, co-wives are obliged to look after the children of a deceased wife. In monogamous situations, a man's mother — if still alive — may have to step in, or his brothers' wives help take care of the children. As one elder noted, *"The problem widowers have is who will look after their children. It's only when the children are neglected that the husband remembers his dead wife constantly"*.

Or, he simply marries another woman. If his wife was thought to have died of AIDS he will not be able to remarry in the community, but may be able to find a new wife from a far away place.

8.2.4 Orphanhood

As was discussed earlier, 34% of all the households in the study reported having orphans, of which one third has lived elsewhere before joining the household. AIDS may not always be the cause of the orphaning event. The Tiv and Idoma people claim that orphans are never left on their own but are in the care of relatives. Idoma children like their Tiv counterparts are usually taken care of by the co-wives, grandparents, or other relatives, but sometimes also parents' friends or neighbours.⁵³

In cases of one-parent orphans, a father can decide where an orphan will go when he can no longer cope, a mother cannot. When both parents are dead, the head of the family, after consulting with the deceased father's closest relatives, decides what to do. Most step-parents use their own resources to care for an orphan. Some receive support from other relatives. If there is a surviving parent, he or she may try to send some money.

Foster parents said that most of the orphans go to school (83%) and only 8% (29 children) of them are engaged in economic activities (with 5 of the 29 children of primary school age). Of the 63 orphans that are not going to school, 24 are younger than 6 years old, 29 are of primary school age, and 10 are older than 12 years. Possibly, some of the enrolled children will not regularly go to school and are kept home because there is no money for school fees or they are needed to work at home or on the farm. Education is free, but parents have to pay for a uniform and for books. In addition, the teachers will also regularly request small contributions for various needs. A school uniform costs about N450 for each child, while costs for books and other levies may reach N1000 for one year at a rural school.

⁵³ Some of the children ended up in one of the few Benue orphanages after their mothers died. The father usually leaves them there for a few years, until he has the resources to properly take care of them.

9 Perception of HIV/AIDS in the Study Communities

Stigma and the subsequent discrimination presents a problem to the effectiveness of prevention efforts such as condom use and HIV/AIDS, the willingness of people to know their HIV-status, the care and support provided and the uptake and adherence to Anti-retroviral treatment (ART) (Foreman, Lyra & Breinbacher, 2003, Nyblade et al. 2003, ICRW, 2002, Brown, MacMacintyre and Trujillo 2003, Taylor & DeYoung 2003). To develop effective strategies for the mitigation of impact and prevention strategies it is important to know the extent of stigmatisation. Although this study did not focus on investigating stigma in depth, people's perceptions of the disease, its origins and implications were discussed in various focus groups, in particular with elders and young people, and during household interviews. The study assessed whether HIV/AIDS was stigmatised and to what extent it could affect the assistance to people living with HIV/AIDS as well as their livelihood strategies.

9.1 Local perceptions of HIV/AIDS and implications for prevention and care.

Participants in the FGD's with male and female elders expressed fear for the future of their children. Parents say that they have tried advising their children to lead responsible lives, but many seem unsure that their warnings will be heeded. There is an element of fatalism in both the parents' and young people's attitudes. Some young people stated that if it happens to them, so be it. Some parents noted that in the end it becomes their children's own responsibility: *"Those who have ears should hear and if they don't listen to advice, it is only God who will protect them!"* Others fear that their children will not escape this dire situation and they worry about the many consequences of living in the shadow of AIDS.

The concern, fatalism and helplessness that speak from the findings reiterate the findings in an earlier study in Benue State among children, adolescents and parents (Benue Health Fund, 2000). Parents feel ill prepared and unable to deal with adolescent sexuality. Although prevention and susceptibility to HIV/AIDS was not the focus of this study these findings draw attention to the urgent need to address adolescent sexuality, sex education and access to services. This urgency is further born out by the implications of the findings reported in previous chapters.

The vulnerable position of women and girls relates not only to the vulnerability in terms of livelihoods but also in relation to susceptibility to HIV/AIDS. Two quotes illustrate vulnerability are also relevant to draw attention to the susceptibility of girls.

"A headmaster pointed out that some girls are poorly educated by their parents and are too naive or feel that they have no choice but to accept an older man's advances; poverty further drives many of them into lifestyles characterised by risky sexual behaviour as this ends up being the only way to pay for their schooling."

Fear of infection is an important issue in most communities, including those that express sympathy for the victims. In eight communities Stigma was expressed in terms of fear of infection and death also showing the low level of knowledge about transmission routes: *'It is not possible because such a disease like AIDS that has no cureone has no option to stay clear' even if it is your brother or sister. There is fear that even discrimination of eating in the same place with the person can make you contract the disease'* (male youth FGD, highly affected).

Only in one community reference was made to a change in attitude towards people living with HIV/AIDS. The change was attributed to listening to Benue State radio.

“We assist them with food and we relate well because Radio Benue Idekpa has told us that we cannot get AIDS by relating with them, e.g. food not risky behaviour. (FGD girls, highly affected community).

The widespread fear of caring for people with HIV/AIDS expressed by the youth in Focus Group Discussions reflects the low level of interventions in the study communities and draws attention to the need to start an education programme on universal precautions whilst caring for people living with HIV/AIDS.

The findings of the FGDs with male and female youth and male elders show a high level of denial of the existence of PLWHAs in the community. The existence of people living with HIV/AIDS in the community was denied in half of the high, medium and as well as low HIV/AIDS affected communities by participants in the FGDs (male and female youth).

In discussions with community leaders denied the presence of HIV/AIDS in two communities, one with high and one with medium affectedness. In one high affected community the youth were signalled to stay quiet when asked how the youth were assisting people living with HIV/AIDS. Researchers noted that there was a strong resistance among the leadership of this community to talk about any chronic illness, while according to others ‘it’ was already present in their locality. A similar finding is reported vulnerable children project that started implementation in October, 1999. They found that any mention of HIV/AIDS was taboo, stigma was high and it was, initially, impossible to conduct any prevention activities in the three Idoma communities targeted. This has important implications for the ability to address prevention and mitigation and shows the urgent need for interventions that will help to reduce stigma.

Possibly, the first community feared that, as a result of the research, their community might be associated with HIV/AIDS leading to major economic and social repercussions. It should be noted that following the broadcast of a Nigerian Television Authority documentary on the impact of the HIV/AIDS epidemic in the Otukpo area in 2000, dealing with the issue in a sensationalised manner, conflict erupted in one of the villages mentioned between the community and a project working on HIV/AIDS related issues. As a result of the broadcast, residents reported serious problems arising, e.g. not being able to sell farm produce and men being unable to find marriage partners. The involvement of a project working on STD and HIV/AIDS, including support groups for PLWHAs, in the preparation of the documentary, fuelled already existing tensions. There was great pressure on the project to end its HIV/AIDS-related activities. Despite conflict resolution work, the project management decided to withdraw from the community in late 2000, while the PLWHA Support Group had virtually ceased to exist (LATH, 2002).

9.2 HIV/AIDS Stigma and its affect on assistance for PLWHA’s

The following quotes show diversity in the level of stigmatisation between communities and the effect of stigmatisation on the willingness to assist households and reiterated the findings in previous chapters showing the efforts to keep the coping with HIV/AIDS private and dependent on the immediate family rather than the extended family and community.

In three communities stigma was expressed by male and female youth during FGDs in answer to questions about the assistance provided to people living with HIV/AIDS in terms of rejection and refusal to provide assistance to PLWHAs.

‘We assist the sick with money for treatment, fetching water and firewood, helping with the farm chores...but not for someone with HIV/AIDS; we just hope the person dies...but if a close relative or friend we will fetch water, clean the room and work on the farm’. (FGD girls comm.highly affected)

The high level of stigmatisation reported from the FGDs are confirmed in interviews with PLWAs in which feared and enacted stigma is reported. The stigma experienced shows how publicly humiliating the unfounded fear of infection is played out in public, and how the fear for rejection directs his way of socialising with others.

As a PLWHA noted: "Once people heard that I was HIV+, they stayed away. My friends have all deserted me. My children are confronted with all sorts of embarrassing remarks and questions. One man even asked his boys to boil water and wash the seats in his house after I visited them. Some people have stopped fetching water from the well in my house because they fear they'll catch the disease. But I have come to terms with my condition." (man PLWHA)

"I am aware that people know about my condition and I can sense their feelings which they try to hide. So I take precautions when I go out to social gatherings, I ask for my food separately to forestall any negative reactions. I don't eat or drink with people even when they invite me". (male PLWHA)

HIV/AIDS is regarded as a deadly disease with no cure. This outlook is so depressing that some prefer to ignore the victims and the issues as much as possible. They are reluctant to spend money on medical care because the situation is seen as hopeless. In one community, many of the people thought it useless to lend money to someone living with AIDS, because they are inevitably going to die before they can ever pay back the loan.

Moral judgement of some has led to the withdrawal of assistance for people living with AIDS. In one community, a support group of widows told how they refused to help one of their own when she fell ill. The following quote clearly illustrates that a group of widows, formed to resist and overcome their vulnerable position and low status, uses strong exclusion criteria for their own members on grounds of sexual behaviour. Although not explored in depth, it is plausible that this rejection is based on fear for negative stereotyping of the group of widows as a whole.

It is because of the specific type of illness she had that we could no longer consider her as a member. She flirted with men, she wouldn't stay in one place, she jumped from one man to another, and then she died of AIDS. She had left home and travelled to the Western part of Nigeria and came back with the illness. This was obvious to us because she had rashes all over her body, she lost weight, had sunken eyes and was always passing water stool. We do not help members of questionable character. Therefore, we didn't help her when she fell ill. But at the individual level, we would still greet her and ask her how she was feeling.

Another group in the same community let it be known they had no inclination to help people with AIDS. *If a person becomes infected with HIV, we simply don't help. This person has obviously lived a reckless life, running after worldly things, and so we don't want to associate with this kind of person.* (FGD Male youth, medium affected community)

In some communities, the relatives of patients are also stigmatised. Parents may be accused of having being the cause of their children's behaviour and resulting illness. This feeling is even stronger for the surviving spouse: *Once a spouse dies of AIDS, the community looks at the surviving one as someone who is also going to die shortly. Nobody wants to marry the surviving spouse.* Widows are sometimes accused of being the cause of their husband's illness or death. One example was of a woman diagnosed with AIDS whose husband had also tested positive for HIV. But she was blamed for transmitting the disease to him because she was the first to fall ill. In the beginning her husband paid for her treatment, but later on she was sent back to her own village and abandoned. The wife claimed that her abandonment had been instigated by her husband's family who became very hostile toward

her. Her children stayed with her husband. She is now dependent on her brothers who take care of her. (Interview with widow whose husband died of AIDS)

People who are not on good terms with relatives and neighbours will receive less support. Some expressed reluctance to assist relatives whom they regarded as lazy or "bad". There was one example of a man, who had never been on good terms with his brothers, being ostracised when he fell ill. This neglect was extended to his widow and child after he died.

Initially, ill people and their close relatives prefer to hide their difficulties from others and opt for strategies that lie within the household's means. They first make use of non-productive assets, avoiding as much as possible any erosion of their resource base (using savings, salary, selling surplus produce). It is only when they can no longer cope on their own that they will involve outsiders in their efforts to deal with the situation. Also, they will try to avoid as long as possible using coping strategies that upset their livelihood strategies, drawing upon the more essential productive assets;

The head of an extended family recalled the support received when two of his brother's sons died one after another. One had been sick for 8 months and the other for over a year. One son had the financial means to pay for his own care and although the immediate family did not help financially, they did visit him in hospital. The other could not pay for his own medical costs, so his father paid the hospital bills, while his wife took care of him. Relatives brought food and visited him in hospital. The church contributed some funds to help pay the hospital expenses. When both of them died, the extended family rallied around the father and the widows and helped arrange the funeral.

The enacted and feared stigma strongly present in almost all communities prevent PLWHAs and their immediate family to keep the illness private and only seek help when there is no other option. This finding is in line with the steps in support received through the social network outlined in chapter 7, figure 7.1.

Households under long-term stress (psychological or financial), and also ill people, may start to withdraw from social networks because they are depressed, do not want to upset others, or can no longer afford to participate. Fourteen percent of all affected households in the household survey felt that illness and death have driven them into social isolation. This was significantly more so for the AIDS-affected households (27%) than for the non-AIDS affected households (9%). Households cultivating less than 3 hectares of land felt significantly more isolated (20%) from their social relations than those with a larger parcel of land under cultivation (3%). The difference between the number of Idoma households (18%) and Tiv households (8%) that reported social isolation was not statistically significant.

"The difficulty I have is the fact that my brothers-in-law want my daughters who are at puberty age to be given in marriage, after which they can collect the bride price and share. My resistance has caused my children and I a lot of problems. It has led to the confiscation of my husband's pension, which I should use to pay for the children's schooling. As a result, my elder son who is in his senior secondary school cannot register for his qualifying examination now, and has to drop out of school".

9.3 Awareness raising and community based education activities.

Most of the awareness raising campaigns were started by the DFID funded LATH STD/HIV/AIDS management project with their partners.

The project was based in Otukpo, Idoma land, and worked through a number of stakeholders such as the St Vincent's mission hospital in Aliade; the Society for Women and Aids in Africa, Nigeria; the clinic and outreach work of the Planned Parenthood Federation of Nigeria, based

in Otukpo with outreach to youth in surrounding villages; the Otukpo LGA; some clinics in the Makurdi area that were associated with the Benue Health Fund. In 10 communities intensive community based education interventions were implemented by the LATH project. State government and LGA bodies participated in some of the sites where LATH and the Benue Health Fund were active, but state-wide awareness raising and community education to develop more positive attitudes was not noticeable in most study communities. The only Education Information and Communication interventions were the Benue State Radio programmes in one community and reference was also made to schools. Even in communities where information is available the interventions have not been able to cut through fear of infection: “

9.4 Concluding remarks

Stigma and discrimination are a serious problem. Stigmatisation and discrimination urgently need to be addressed from a human rights perspective, as well as, to enhance the effectiveness of prevention and care. The silence surrounding the disease hampers communities and individuals in their ability to actively deal with the epidemic, both in terms of prevention, home-based care and impact mitigation. The organization of PLWHA support groups is taking place mainly outside the village or in secret, which is more easily achieved in peri-urban and urban areas. PLWHAs and caregivers living in more rural and isolated communities are denied the support to live positively with HIV and AIDS, regaining their self esteem. In addition, the fear of infection is exacerbated by the lack of knowledge of precaution measures making the caring for the person suffering from AIDS related illnesses much more difficult.

Most people living with AIDS and their relatives prefer to keep their HIV infection and AIDS related illnesses private. At present, disclosure seems too risky with no identifiable advantages. On the contrary, it may reduce the amount of assistance, stigmatise the patient and his/her relatives, as well as affect the status of the entire household.

Special attention is needed for the gender dimension of stigma and discrimination. Women and girls are blamed for spreading the epidemic in general, which may have consequences for prevention work. Widows are accused of having caused their husband's HIV infection. This is then used as a pretext for the family-in-law to strip widows of their assets and to deny them any support, aggravating the slide in poverty of female-headed households. Because students often have to pay their own school fees, poverty may drive girls into risky relationships, which will render them more vulnerable to infection. (Benue Health Fund, 2000). Married women who are ill are sent back to their parents.

10 Discussion, conclusions and recommendations

10.1 Epidemiology and Projections of the Consequences of Increasing Mortality

Data from our household survey indicate that 20% (100 households) of the study households are affected by chronic illness and the death (all causes) of adults aged between 15-49 years over a period of 5 years. Within this group, 29% of the households (with 40 individual cases) are estimated to be affected by AIDS, based on a conservative categorisation of HIV/AIDS related symptoms and causes. This is 6% of all study households. Across the 12 communities in our sample, the percentages of AIDS-affected households ranged from 0 to 16%. Possibly, strong denial and stigma about HIV/AIDS have led to an underreporting of the symptoms associated with AIDS.

This study reported 36 AIDS deaths and 70 non-AIDS deaths on a total of 1423 economically active⁵⁴ individuals over a period of 5 years, which equals a 0.51% AIDS death rate per year, and a 0.98% non-AIDS death rate (total of 1.50% death rate). This figure for AIDS death rate is similar to the AIDS death rate of 0.53%⁵⁵ in Benue State as projected by Ssenozi and Moreland for the year 2000 (Policy Project, 2001). These findings suggest that the sample of our study reflects the expected trends sufficiently and can be used for projections, even though it was not a random population based sample.

The average time from HIV infection to death is estimated to be 5-7 years for HIV-1 infection and 7-10 years for HIV-2, depending on a PLWHA status of health, treatment of opportunistic infections, and access to ARV. In Benue, HIV-1 is the most important virus in Benue. The more than 250,000 individuals in Benue, estimated to be HIV positive in 2001⁵⁶ will fall ill and die in the period up to 2010, when assuming that ARVs will not become widely available. Possible new cases of HIV infection are not taken into consideration. The Policy Project projected an annual number of AIDS deaths of 29,300 in 2010, which is 3 times the number of AIDS deaths in 2000 (which was 9900). Although the absolute number of AIDS deaths will triple over a period of 10 years, AIDS death rates will multiply by 2.4 given the overall population growth (from 0.53% to 1.27%, Policy Project, 2001). Assuming that non-AIDS death rates will not change until 2010, the total death rate will increase from 1.50 to 2.25%, which is an increase of 50%. Benue State is thus facing growing morbidity and doubling of mortality of adults as a result of HIV infections, if ARVs are not made available and accessible.

When projecting the study findings on medical expenses to the estimated spread of the HIV/AIDS epidemic, the total expenditure between now and 2010 in Benue State would equal a total of 9900 million Naira for medical expenses (considering only the 6 month reference

⁵⁴ To connect the data of this study with the projections made by the Policy Project, an estimation of the economically active age group is needed. This study recorded the number of economically active and inactive individuals per household, but not their age. The total number of economically active people in this study refers to the population between 15 and 49 yrs. Officially, the economically active age group is from 15 to 65 years, but in African societies the upper age limit is in reality lower. In Nigeria, for example, the average life expectancy rate for both men and women is only around 50 years of age.

⁵⁵ 9900 AIDS deaths on a total population of 3.4 million of which 55% (CWIQ, 2001)⁵⁵ is in the economically active group. Since AIDS deaths concern mostly the age group 15-49, mortality rates should be calculated for that section of the population only.

⁵⁶ Policy Project, 2001

period of the survey), in addition to the costs made by health services not covered by user contributions. The total expenditure of households on funerals of PLWHA will rise to at least 4800 million Naira in 2010, assuming that present practices of rites around burials will not change. These figures do not include the expenditures in kind, nor what households contribute to funerals of relatives, friends and neighbours.

Time spent on mourning and funeral rites for men and women will increase by 50% in conjunction with the increase in death rates. In 2010, Idoma male heads of households are expected to spend 90 days instead of 60 days at funerals and in mourning, their wives will spend even more time (100 days instead of 67). Tiv male heads of households and their wives both spent 22 days at funerals and in mourning according to our survey, this will increase to 33 days in 2010.

The implications of the epidemic are much larger than a significant increase in medical and funeral related expenditure or time spent on care and at burials. The epidemic may affect the capacities and strength of the workforce, labour availability, productivity and investments in Benue State for the next decennia, as will be discussed later in this chapter. It will affect consumption of goods and services, including health and education, further influencing economic development.

People now dying due to AIDS are young, on average 29 years in our study, with disproportionately more women. This is the generation that will have young children, provide support to their parents, and are the main force of community based organisations and groups. These groups do most of the work to maintain and build infrastructure, organise community gatherings and play an important role in local safety nets. This generation is also an important part of the knowledge transfer chain and introduces innovations.

Moreover, our study showed that PLWHA were more involved in off-farm activities than the heads of households, which may have increased their susceptibility to infection. Their involvement in trading may have improved the effectiveness of marketing of household produce, while such activities also provide more regular income, instead of relying only on the harvest. These people are likely to have been more mobile and therefore a source of information, contacts and entry points into townships and urban centres. Losing so many young people has severe implications for their families and for their communities, but also for Benue State.

10.2 Direct implications of illness and death

Direct implications of illness and death fall under two categories. Firstly, there are direct cost implications because of increased medical and funeral expenses. Medical costs reported are significantly higher for households affected by AIDS than for households dealing with illness or death due to other causes. Funeral and burial costs are not influenced by the cause of death. On average for a period of 6 months, households spent N 30.000. As will be discussed in the next section, these amounts force households to resort to coping strategies.

What makes the situation different in the case of AIDS is that people do not recover. As a group of girls observed: *"All the money in the house is spent on the sickness that does not finish. The person still dies even after spending all that money"*. It was reported that other households are less willing to contribute to medical expenses when the condition of the ill person is considered as fatal. Our data do not suggest that medical care is denied to PLWHA, although some case studies seem to suggest that some PLWHA stop treatment when

informed about their seroprevalence status. The question is what will happen with respect to the availability of support when levels of morbidity increase even more, while the resources of the PLWHA and first-line relatives are exhausted.

In Benue State, at the time of the study, ARV treatment was made available to very few selected PLWHA for N10.000 a month. Data on medical expenditures show a preparedness to pay, in particular when recovery is expected. Present levels of expenditure on medical expenses are not enough to pay for ARV treatment. Moreover, these expenditures are already considerable when compared to average income levels, and most likely involve a pooling of resources. The question is how much more can households afford to pay and for how long, without having to resort to irreversible changes in livelihood strategies. Much will depend on the effects of ARV on the PLWHA's capacity to work (again) and earn an adequate income to pay for such costs.

Secondly, for the affected household there are labour and income implications due to absolute loss of labour and reduced productivity of both the PLWHA and the caregivers, as well as time consuming mourning rituals. Affected households reported that they became less productive through a lack of concentration and depression as a result of emotional responses to the illness in the household. Strategies to alleviate labour constraints include the use of hired labour, increasing the workload of other family members, calling upon community-based organizations or reducing/abandoning a certain activity. With respect to trading and business, replacement seems difficult and these activities often come to a (temporary) hold. Household chores are divided over more people (co-wives, youngsters, children), often leading to a growing workload. Family members, living elsewhere, may be called upon. Possibly, children are taken out of school to help out, temporary, but this was not reported explicitly.

Care is given by men, women, boys and girls. On average, members of an affected household spend 12.1 hours on care per week. Women spend most time (14 hours) and boys least (10 hours). Data on the amount of time spent on care by the entire household are not available. A study in South Africa found that care giving took about 4 hours a day for AIDS-affected households (Booyesen and Bachmann, 2002).

This study found no evidence, however, that illness and death among young adults is causing more labour scarcity than already experienced in some communities. In their quest to employ young people, mostly men, farmers in communities closer to town have to compete with urban demand. There is also migrant labour from inside and outside the State. Labour markets are more active as a result of HIV/AIDS because of the increased demand for hired labour to replace ill people and care givers, and increased supply of labour from those households who can no longer cope. Most affected households in our sample still have the means to pay for hired labour, but some households started cutting back on hiring labour.

10.3 Outcomes of chronic illness and death for livelihood security and well-being

10.3.1 Responding to chronic illness and death and impact on livelihoods

General patterns of coping with the effects of AIDS do not differ between various parts of Africa and are comparable to those used to deal with other crisis, such as food insecurity. The broad options to pay for extra costs are : draw upon reserves, reduce expenses, liquidate assets, attempt to generate extra cash, and call upon support networks (for AIDS impact

studies in East and Southern Africa see; Mbaya 2002, Drimie 2002, Mutagandura et al. 1999, Rugalema 1999; studies documenting responses to food insecurity: Ainsworth and Over, 1992; Campbell, 1990; Corbett, 1988 and Longhurst, 1986).

However, what is exactly done is context-specific. Moreover, coping strategies used vary between households and are influenced by similar factors determining vulnerability. It is only through a more detailed analysis of coping strategies that possibilities for policy and programmes can be identified.

An important finding of this study is that the coping pattern of AIDS-affected households in Benue does not yet differ from that of households affected by other diseases. One explanation is that there are not yet many households that have experienced multiple cases of illness and death. It is also possible that the indicators used to classify households according to wealth were not robust enough. Moreover, the focus was on wealth of the household and not of the PLWHA. No research was done on intra-household income streams or the pooling of resources. As is discussed in previous chapters, intra household poverty could not be captured by the research methodology used.

A small group of households, however, were reporting the use of more erosive coping strategies. In this study, 17 % of the households reported using potentially erosive coping strategies (casual labour, cutting down on school fees, selling land). Half of them were female-headed households. Given the projected spread of the epidemic, it is likely that more households will need to use erosive strategies in future when alternatives are no longer available. This trend has already been noted in other countries (Shah et al., 2002). These households may become more and more reliant on forms of self-employment or employment that generate cash quickly, when the members are still strong enough to work. When this is no longer possible, they become depended on local welfare and handouts.

In the following paragraphs, we anticipate the long-term consequences of responding to illness and death on material livelihoods and social well-being in a context of increasing numbers of AIDS-related illness and death.

10.3.2 Lack of cash, lack of investments

Because of illness and death, resources and savings set aside for other projects were used for medical and funeral expenses. During the PRA, all households experiencing illness and death of adults told that plans for the expansion of fields and agricultural operations, trades or enterprises and plans to send children to secondary education or to improve housing conditions were postponed or abandoned. Replacement of durables is delayed and there is no money for what people would call 'luxuries', such as a new dress.

Households experienced a reduction in working capital, possibilities to invest, reduced savings, or ended up with debts. For example, 32% of the affected households with a CIP had debts and 50% of those who experienced death. The reduction of working capital leads to cuts in investment for farming (seeds, inputs, hired labour) but also in business and trading activities. Informal savings and credit associations are often the only way to obtain loans, but chronic illness can lead to reduced eligibility for loans from *bams*.

An increase in morbidity and mortality could affect these informal financial institutions if it implies that people have less money available to invest in these associations, more people ask for loans, and more members have problems with repayment. Availability of informal

finance would be affected. None of the organisers of these informal financial organisation reported such problems yet.

Diverting savings and investments into care and funerals will affect economic development, as was also observed for South Africa (Drimie, 2002). This is also the mid-term prospect for Benue State if the epidemic is allowed to spread further. As a result, households can invest less, local credit and savings institutions are undermined, productivity will fall, consumption will be reduced, and there will be less demand for hired labour, making it even harder for the very poor to earn a living.

10.3.3 Changing livelihood activities

Coping with chronic illness and death has resulted in intended and unintended changes in livelihoods activities: with respect to scale and diversification. The scale of activities changed for some respondents. For example, several women reported raising additional cash quickly through agro-processing while other men and women had to take up casual work, often at the expense of working on their own farm. Farming operations generally were reduced in scale due to a decline in investments.

Other households abandoned certain activities altogether, resulting in less diversified livelihoods. In the household survey, four out of 100 affected households mentioned having to abandon their main livelihood activity⁵⁷ as a result of illness or death. Households reported the suspension of trading activities, mostly due to a lack of working capital, and sometimes crafts work due to lack of time. Some reported that remittances from urban-based PLWHAs fell away. Others had to sell their motorbike to raise cash, which implied the ending of an income-generating activity, as these bikes are commonly rented out for taxi services.

A study conducted in Malawi (Mbaya, 2002) reported that as a result of dealing with the effects of HIV/AIDS, land-based activities were becoming more important because other activities such as self-employment and trading, suffer more. This seems to happen also to some household in Benue who used to have more diversified livelihoods. For poorer households, however, with no reserves and no income, work on their own field seems to be replaced by activities which generate income much faster. Moreover, female headed households have limited access to land and will have to look for other ways of earning a living.

Studies from other countries also found that members of affected households seek income opportunities in urban areas in order to contribute to the high expenses back home (Drimie, 2002). This was not mentioned in the course of the interviews, but is not an unlikely option given the importance of migration as a livelihood strategy in Benue. Increased migration, is likely to increase urban poverty given the state of the economy.

10.3.4 Reduced food and nutrition security

Farming systems are under stress for many farmers, resulting in a decline in harvest and shift to cassava. Remittances and income from other sources also decreases for many affected households. Moreover, some coping strategies may cause household food insecurity in the short and long run. Selling more than the surplus production may jeopardize the food security of households at the end of that season. Selling too many seeds, fewer investments in

⁵⁷ This was not specified.

farming, engaging in casual labour, and selling or leasing land jeopardises food security during the following agricultural season. Indeed, Loevinsohn and Whiteside, 2001, also mentioned that AIDS affects food availability (falling production); food access (less income for food purchase); and, the stability and quality of food supplies (as a result of shift to less labour-intensive crops). When consumption patterns follow the shift in production from yam to cassava, this will have nutritional consequences, especially for PLWHA whose nutritional requirements are up to 50% greater for protein and 15% for energy than that of healthy people (Piwoz and Preble, 2000). Cassava contains less protein, and is generally considered to be a low quality food.

This study found that food consumption of households under stress is being reduced in terms of both quality and quantity. Affected households reduce the number of meals (13%) they have, mainly from 3 to 2 meals per day and change the composition of their meals (16%) (data not presented, no significant differences). More AIDS-affected households (27%) change their meal composition (consumption of yam, meat and beans to cassava) than non-AIDS affected (12%). More Idoma households changed their main food type consumed than Tiv (20% vs 11%).⁵⁸

10.3.5 Social networks and safety nets

With regard to the social organisation, there is a well-structured system of traditional leaders and family clans. Culturally, the concept of solidarity with those who are suffering is central in Benue State. Respondents stated repeatedly that *'there is always help'*. Nonetheless, in practice, help is not always there; it may not be in time, it may not be sufficient, or it may be provided under certain preconditions. Most study households receive support in various forms, although the frequency differs between ethnic groups, with more Tiv reporting having received support than Idoma.

However, welfare support is erratic. The least well-off people will be most dependent on charity and gifts, but this is also the group that can least afford the costs of membership, let alone ensure reciprocity. Moreover, AIDS-affected households suffer from greater social isolation than households experiencing chronic illness or death from other causes. People withdraw actively from social networks because of self-stigmatisation and stigmatisation by others. Others stop participating because they can no longer afford the contributions or feel too depressed to attend such gatherings.

Existing safety nets are based essentially on the extended family and to a lesser extent on community-based organizations, such as age-groups, faith-based groups and youth groups. First-line relatives are the most important source of support for the ill, the grieving and the bereaved. Sick people move or are forced to move between households, which for the latter either implies sharing the burden of care or displacing it. The strength and connectedness of the social networks within families and in the community will determine how far the ripples go. The willingness and capacity of the extended family to cope depends on the relative level of wealth of the members, and the number of requests for support and the strength of solidarity. In some communities, informants were complaining that there is too much demand for help these days, but there was no evidence yet that these networks are becoming overstretched. Experiences in Southern Africa suggest that with increased prevalence the traditional community safety nets may become overwhelmed, resulting in relatives refusing support such as for fostering orphans.

⁵⁸ These differences (AIDS/non-AIDS; Idoma/Tiv) are not statistically significant

Will the extended family be able to continue absorbing orphans and treating them equal to other children? What will happen to solidarity and will households remain prepared to support directly affected households, at the expense of their own livelihood strategies? It should be noted that in countries where the epidemic is more advanced, home-based care organizations involving volunteers have emerged, which have prevented the existing safety nets from collapsing and improved the quality of care.

In most communities included in our study, NGOs or PLWHA support groups are not reported to be active in the study communities. Religious organisations should also be mentioned; traditional (although in decline), Christian churches, and to a much lesser extent Islamic institutions. Faith-based organisations are found in all communities and usually have the largest memberships, but do not seem to focus on charity work as an institution, although the church members do. However, again they can easily become a source of vulnerability when they stigmatise PLWHA and their relatives.

10.4 Vulnerability to the impact of chronic illness and death

10.4.1 HIV/AIDS in a context of growing poverty

The HIV/AIDS epidemic is not the only crisis that people in Benue have to deal with. In Nigeria, the economy collapsed in the 1990s while government support for infrastructure and basic services declined considerably during the period of the military dictatorship, which ended in 1998. In this period, the government was not prepared to face the growing HIV/AIDS crisis. Only courageous Nigerians, such as Fela Kuti and his family, were raising the alarm. Democracy returned in 1999. The new government not only had to build more efficient, transparent and accountable governance systems but also had to deal with other challenges such as economic depression, a neglected health and education sector and dilapidated infrastructure.

Economic and social deprivation is experienced by many people in Benue State (65% of the people are extremely or moderately poor). The poverty as experienced by rural people and communities in Benue State experience make them more vulnerable, and possibly also more susceptible, to additional crisis such as the spread of HIV/AIDS, which in turn exacerbates the above-mentioned problems. In Southern Africa where the epidemic is more mature and has been undermining society for longer, it is argued that HIV/AIDS may increase the vulnerability of communities and households to drought and other crisis, while also reducing the capacity of these societies to respond as the strength of adults in particular is undermined (Barnett and Whiteside, 2002, Devereux 2002, Oxfam International and Save the Children UK, 2002, Loevinsohn and Gillespie, 2003b, Waal and Tumushabe, 2003).

The economy in Benue mostly depends on agriculture and spin-off activities such as processing, trading and casual labour. One source of enhanced vulnerability is a decline in remittances received from urban-based relatives. These migrants are being hit by the economic crisis as well, but increasing morbidity and mortality is of influence too. Furthermore, outbreaks of violence and insecurity took place in Benue and the surrounding States, affecting local livelihoods. The latest confrontation was in 2001 and displaced many people.

Farming is under stress due to worsening terms of trade, and input markets that are not functioning well. These developments prevent investments required to halt a decline in soil fertility and many farmers in Benue State are experiencing a drop in overall production and income. Over the past decade, farming has actually become more labour-intensive per unit of harvest. In particular, the workload of women increased. In response, farmers hire labour and the gender division of labour has become less strict with men becoming more involved in crop maintenance. This trend is found in both Tiv and Idoma communities, and is becoming a constraint to livelihoods in six of our study sites. Its impact on particular households depends broadly on land availability, crop choice and access to fertilisers and hired labour.

Changes in crop mixtures, mostly from yam to cassava, can help sustain staple food production and reduce the risk of food insecurity, while the effects on income depend on the market prices for the alternative crops. Despite these adjustments, farmers have less return for their investments and may even see an actual overall decline in their harvests. These developments increase the vulnerability of both households and communities to shocks.

Present changes in farming systems in Benue are not caused by the spread of HIV/AIDS, but may be exacerbated by the epidemic. The advantage for affected households and communities is, however, that knowledge on growing cassava is widely available, technology innovations are already introduced (in particular varieties) and markets for produce have been developed. This may cushion the impact of HIV/AIDS on rural livelihoods.

10.4.2 Widows, orphans and the elderly

Widows

The percentage of female headed households among the affected households was not different from the general study population. Widows become the head of their households, remarry, or return to their own family. When households absorb a widow and her children, her impoverishment becomes probably less visible.

Not all female headed households are poor, and our data suggest that 10-20% of these households are well-off, but also that about 60% is poor. Widows with small children are most at risk of becoming destitute. Widows are more often discriminated against than widowers when AIDS is suspected to have caused the death of the spouse.

The support systems described in the previous section help affected families to cope and restore their livelihoods and should offer protection to the bereaved. However, these systems starts to fail some widows, although initially not as a result of the spread of HIV/AIDS but more due to cultural changes and possibly growing poverty. In Tiv as well as Idoma land, the position of a widow depends on the quality of the relationship with her in-laws, whether she has male children of a certain age. The way widows are treated is much harsher among the Idoma, as none of the Tiv widows indicated that they were completely disinherited. Both Tiv and Idoma widows found it difficult to make ends meet after the death of their husbands.

Brothers of the deceased husband played a major role in supporting widows and used to marry them, a practice which is now on the decline but has not been replaced by other support systems. For widows, much less support is made available these days by their family-in-law, and they have become more dependent on their own family. Some widows in Idoma land described how they lost access to land and other goods following the death of their husband. Widows in Tiv land also have to shoulder more responsibility. These problems will affect their children too. As a result of these developments, they live in more impoverished

households and may have much weaker rights to land and less strong links with the family of their father.

Orphans

More AIDS-affected households foster orphans than non-AIDS affected households. This study has not found evidence of exploitation and abuse of orphans as is often mentioned for East and Southern African countries (UNICEF/UNAIDS 1999 and 2002). Respondents mostly voiced pity and the importance of not upsetting orphans. Still, households that have used up their reserves to pay for medical and funeral costs, widows that have become impoverished, will not be able to provide their children with a solid resource base to start off in life.

However, the methodology used in this study was not specifically designed to study livelihoods of orphans and the position of children in foster families. Studies conducted in East Africa (Rugalema, 1999) reported a more intensive use of child labour in fields or for care giving, and taking children out of school by foster families. The present study has found some evidence for such practices, since 13% of the primary school age orphans did not go to school. Other orphans are enrolled at school, although no information is available on their attendance. Project information obtained during the work with sex workers and youth suggested that foster children are a potentially highly vulnerable to sexual violence (LATH, 2003a). There are indications also that girl orphans are at risk of early marriage, around the age of 15.

Because the increase in orphan rates and of impact more generally lags behind HIV infection levels by about 10 years, it is expected that Benue State will face a major increase in the number of orphans in the near future.

Caring for grandchildren

Studies from Southern Africa reported that grandparents, men and women, play an increasingly important role in the upbringing of their orphaned grandchildren. In Benue, this is not yet a wide scale problem as 10% of the orphans are living with their grandparents, but who found it hard to cope. This percentage may grow in future given the expected increase in orphaning. It is possible that the elderly will increasingly be required to work on the land and carry out essential tasks, for which they need support (Marcus, 2000 in Drimie, 2002, Topouzis, 1994).

10.5 Impact on rural services

HIV/AIDS also affects formal institutions operating in rural areas such as health, education or agricultural support services, or local government. Mortality data on agricultural support services staff (BNARDA) show an increase at rates similar to the general population. Statistics over the past 10 years indicate that mortality amongst all its staff has increased steadily in recent years (Figure 10.1). Medical and burial expenses paid by BNARDA have been cut back over the past few years, since these levels depend on the overall budget, which has steadily gone down since the World Bank funding for BNARDA stopped. Funeral expenses per individual are paid by the State Government; the allowance depending on the salary scale of the individual (no data available).

Mortality or morbidity data for health and education workers have not been collected in this study, but research conducted in other countries indicate that these employees are at high

risk to HIV infection (World Bank, 2002). This will have detrimental effects on the provision of basic services, which are an essential tool for achieving the Millennium Development Goals (Sachs, 2001). A further spread of the HIV/AIDS epidemic will undermine further service provision in rural areas, which is already poor. This will make it difficult to reduce medical costs for PLWHA and ensure appropriate care which would help them survive longer. Another implication is that the introduction of ARVs through the health system may not be realistic, without considerable investment and capacity building.

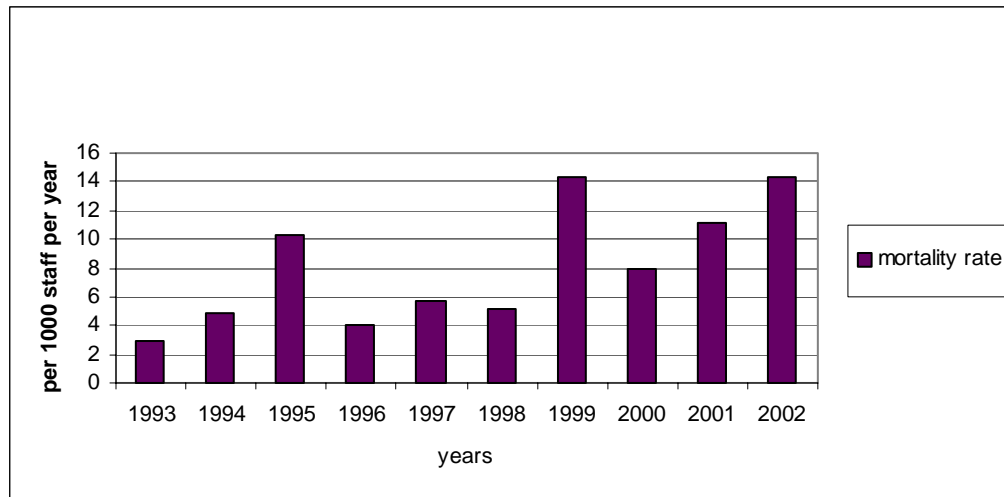


Figure 10.1: Mortality rate among BNARDA staff

Sector ministries play a key role in joint efforts needed to stop the spread of HIV infections, eradicate stigma, improve care and support and mitigate impact. This requires effective interaction between the different stakeholders involved (UNAIDS, 2002). The challenge for Benue is that these activities have to be undertaken with organisations that are under-resourced and have faced mostly decline over the last decades. The World Bank Multisectoral AIDS Programme and the recently started DFID project "Strengthening Nigeria's Response to HIV/AIDS" provide sufficient resources to assist community organizations, community leaders, extension workers, such as those employed by BNARDA, and local governments to move towards the implementation of effective strategies in all communities in Benue State.

The approach adopted should be multisectoral. Multi-sectoral collaboration, however, does not mean that agricultural extension workers must become AIDS prevention workers. A sector organisation should focus on its core business, yet at the same time meeting its responsibility towards its employees and 'clients' in creating an enabling environment for AIDS prevention. An effective workplace programme is needed to protect existing human resources from infection so as to guarantee future service delivery and capacity. Moreover, all sectors need to include HIV/AIDS impact assessments of their workplan and working methodology to reduce susceptibility to HIV infection.

The spread of the epidemic will affect productivity and investment capacity in Benue State which should be taken into account in workplans. BNARDA should also assess whether their services are appropriate for directly affected households and communities, indeed responding to their specific needs. With the changing composition of households BNARDA has to focus its messages on the felt needs, interests and constraints of female-headed households; those

caring for people; and, elderly or young people taking over farming, which are not the traditional target groups of extension services.

10.6 Opportunities for action

HIV/AIDS in Benue State has become a generalized epidemic. Unless ARVs become widely available, the suffering and loss of life this entails will have a devastating impact on the livelihoods of its people, on social networks and support systems, and the economic prospects of Benue State in the coming decades. There is still time to act: to prevent new infections, to improve the health and quality of life of PLWHA, to support home based care, and to prepare all actors on how best to mitigate the expected impacts of the epidemic.

Action is needed for four main purposes:

1. Eradicating the stigma
2. Prevention of HIV infection
3. Care and support for PLWHAs as well as caregivers
4. Mitigation of impact

Eradicating stigma, care and support and mitigation of impact will be discussed below. Some suggestions for Benue State are given, using examples of promising practices from elsewhere (FAO 2003, Bonnard, 2002, IFAD 2001, UNAIDS Local Response Initiative (forthcoming) and Loevinsohn and Gillespie, 2003a and 2003b) and the recommendations from the experiences of the LATH project in Benue State (LATH, 2003a, 2003b).

Clearly, prevention of HIV infection is key to reduce the spread of HIV/AIDS and impact, but an assessment of ongoing programmes and initiatives was not the focus of this study. However, it should be emphasised that, beyond the radio programmes and awareness raising activities amongst youth in some communities only, none of the study communities were actively addressing prevention of HIV/AIDS.⁵⁹ Radio station do broadcast information on prevention and precautionary principle for providing care, but may have contributed to stigmatisation too.⁶⁰ There is an urgent need to give much more attention to appropriate prevention work that reaches all rural communities.

It is important to be aware of enhanced susceptibility to risk of infection caused by poverty and inequality. Many livelihood activities that people undertake to raise some extra income make them susceptible to living and working in risky situations, such as migration, trading and hawking. Particular the desire of youngsters to escape from farming and gain some independence should be a cause of concern as many then work as casual labourer around markets and restaurants, again surroundings where people are more at risk. The poverty of students following higher education often away from home is another point of concern.

10.6.1 Eradicating Stigma

Stigma and discrimination are a serious problem affecting both prevention and mitigation of impact. Stigmatisation and discrimination urgently need to be addressed from a human rights perspective, as well as, to enhance the effectiveness of prevention and care. The silence

⁵⁹ Benue is a crossroad for long distance transport, and several prevention programmes are in place to deal specifically with truckdrivers and sexworkers.

⁶⁰ In one community respondents initially refused that interviews on AIDS related issues would be recorded, fearing that these would be broadcasted on local radio stations.

surrounding the disease hampers communities and individuals in their ability to actively deal with the epidemic, both in terms of prevention, home-based care and impact mitigation. Fear of rejection and social exclusion that was observed in others, and inability to access loans and credit cause PLWHAs and their families to keep the nature of the disease private and ask assistance initially only from the immediate family. The organization of PLWHA support groups is taking place mainly outside the village or in secret, which is more easily achieved in peri-urban and urban areas. PLWHAs and caregivers living in more rural and isolated communities are denied the support to live positively with HIV and AIDS, regaining their self esteem. In addition, the fear of infection is exacerbated by the lack of knowledge of precaution measures making the caring for the person suffering from AIDS related illnesses much more difficult.

Special attention is needed for the gender dimension of stigma and discrimination. Women and girls are blamed for spreading the epidemic in general, which may have consequences for prevention work. Widows are accused of having caused their husband's HIV infection. This is then used as a pretext for the family-in-law to strip widows of their assets and to deny them any support, aggravating the slide in poverty of female-headed households. Because students often have to pay their own school fees, poverty may drive girls into risky relationships, which will render them more vulnerable to infection. (Benue Health Fund, 2000).

Parker et al. (2003) found that the most powerful and effective response to HIV/AIDS takes place when '*affected communities mobilise themselves to fight back against stigmatisation and oppression in relation to their lives*'. However, community mobilisation is only possible if stigmatisation is addressed and more public and empathetic responses are generated. Participatory community based interventions offer the best chance for success but the complexities and time involved to produce results need to be clearly understood to avoid frustration and untimely stopping of these actions, (Campbell, 2003).

Community development approaches are already developed in other places in Benue State but lack of trained facilitators and resources has limited the interventions to a limited number of communities. These experiences can be further developed and implemented Benue State wide. In addition, work with already existing widow support groups could address the vulnerable position of widows and generate discussion about the unfair treatment of widows in the wider community.

The recommendations in the LATH reports and briefing papers provide good entry points for mainstreaming gender. The LATH policy briefing papers give further guidance to the context specific ways in which stigma and discrimination can be addressed (LATH, 2003a and b). The UNDP training materials provide further background materials for the training of trainers, addressing stigma, discrimination, universal precautions and the development of action plans. Especially the wildfire exercise forms a good starting point for community development activities (UNDP, 2000).

The greatest challenge will be to move beyond training into implementation of interventions in all communities involving both civil societies and State and Local government bodies and services.

10.6.2 Care and support for PLWHA

Medical costs are significantly higher for PLWHA than for other chronically ill people. The health system at local level is in a poor condition and people will have to travel to townships to get hold of medication, or buy at markets. Good medical care for PLWHA, including very limited access to ARVs, is only available in the few hospitals found in the State. Setting up systems for essential drug provision is important to improve availability and quality, and possibly to reduce costs. Given that people do pay considerable amounts of money for medical care, it should be possible to design sustainable cost recovery systems in close consultation with users of such services.

Promoting the availability of direct medical care within the communities would reduce transportation costs and improve care. To enhance drug availability, treatments of opportunistic infections should be included in the list of essential drugs, and ideally, ARVs would become available. The question is how best to achieve this given the state of the government funded health service and whether more community involvement in service delivery would be an option.

Care givers need support and training in precautionary principles and special needs of PLWHA. Improvement of nutrition, hygiene and access to treatment for opportunistic infections and ARVs can prolong the life of a PLWHA and enhance his or her quality of life. The patient remains productive and takes care of his or her children for a longer period of time.

Nutritional care is one of the components of the so-called 'minimum AIDS care and support package'. International guidelines have been developed for the nutritional care of PLWHAs in 2002 (FAO/WHO) and Nigeria has developed national guidelines on infant feeding and HIV/AIDS (Federal Ministry of Health, 2001c). Local guidelines on nutritional care for PLWHA and living positively with HIV/AIDS have also been developed in Uganda and Tanzania. The review, updating, adaptation and subsequent broad dissemination of these guidelines is necessary, along with training.

Hygiene and access to safe water is a problem in Benue. The majority of the population still relies on streams and ponds, many of which dry up during the dry seasons (see 3.1). This situation not only increases risks for PLWHA but fetching water is also time-consuming. Fuel wood availability is also a problem for part of the households in our study, making boiling water a challenge.

Spiritual support and psycho-social counselling for the PLWHA, as well as for the care-givers and other family members, is as important as treatment. It is being given in communities and is greatly valued by affected families. Psycho-social support is also provided by PLWHA support groups. They provide advice and moral support, help to reduce stigma, and can also provide access to better care. In Benue, such groups are mainly initiated by the mission hospitals and not yet by the communities. Due to stigma, PLWHAs prefer to join support groups far from their communities. This experience is similar to the start of such groups in Uganda in the early 1990s but eventually made great inroads.

10.6.3 Mitigation of the impact of chronic illness and death

Three different levels for mitigation impact can be identified: 1) Reduce the immediate effects of illness and death; 2) Reduce impact on livelihoods; and, 3) Provide social protection for the most vulnerable groups.

Reduce the immediate consequences of illness and death

Immediate consequences of illness and death, such as loss of labour, high costs for medical treatment and funerals can trigger a household's downward spiral into poverty.

Funeral, burial and mourning rites are very costly in terms of money and time, making it even harder for the bereaved to restore their livelihoods. Some of the elaborate funeral practices were only recently introduced in Tiv land, while mourning rites in Idoma land have shortened from years to months, although not in response to the HIV/AIDS epidemic. Moreover family heads can decide to alter the funeral arrangements and the length of the mourning period. Given that mortality rates are likely to increase in the coming years and the negative impact of these rituals on the livelihoods of many, it is important to start discussions now on possibilities for reducing the costs for the bereaved, while still being able to pay respect to the deceased person and observe customary rites. The community and the clan are in a position to propose changes and churches are of influence too. Dialogue should be promoted between family, community and religious to analyse the consequences of these rituals and identify alternatives.

Family labour availability is affected by HIV/AIDS. Hiring labour should not become a problem in future, when a household has the resources to pay, given the availability of migrant labour in Benue and the fact that growing numbers of impoverished households start working as a casual labour. It is possible that 'free' labour provided by family or community associations may become less available when the epidemic advances. Especially community associations are likely to be affected if growing numbers of young people fall ill, which is the core of their membership.

To deal with the loss of labour, labour and time-saving technologies are often one of the first suggested avenues, in particular for agriculture (IFAD, 2001; Bonnard, 2002; and FAO 2003). However, there have been many attempts to introduce labour-saving devices in the past, when HIV/AIDS was not yet a problem. It is therefore important to first understand why previous efforts have not succeeded before embarking on a new campaign. Moreover, the more appropriate area for action in Benue is not necessary agriculture, as the technology for growing cassava, one of the more obvious alternatives, is well known. Mechanising soil preparation would require too many changes in farming systems. Improving the availability of tractors as well as of herbicides of good quality, to reduce weeding, would already go a long way in reducing labour requirements. More important seems a better availability of processing equipment for cassava in particular and to reduce the burden of household chores (fetching water and fuelwood).

Reduce epidemic impact on livelihoods

Poverty alleviation will increase the resilience of households, and is therefore of great importance for affected households. These include productivity of farming, the diversification of livelihoods and creating opportunities for self-employment, not requiring much investment.

Small livestock, even where households own just a few heads, is used to pay for emergencies and other cash needs, but epidemics regularly wipe out these animals. Support for the existing livestock sector; in particular chicken, ducks, small ruminants, pigs, may come across

as very specific, but it is of great importance to rural households in Benue. BNARDA has experience in the control of livestock diseases and could elaborate its activities in this field.

Access to casual work or self-employment that provides an income at the end of the day is important for households who need to raise cash quickly. Women, in particular, often turn to agro-processing but there are indications that processing equipment is not widely available while market demand also seems erratic. A sector analysis is needed with a focus on facilitating accessible and affordable processing facilities (see also section on labour saving devices).

Access to credit is essential to improve production and investments, to cushion the impact of the illness and to maintain a diversified portfolio of livelihood activities. Informal saving and credit organizations are the most important source of such services in Benue State. They are accessible for most men and women, although not the poorest who are not considered creditworthy by their peers. There are indications that people who are suspected of having AIDS and probably also their close relatives are no longer considered creditworthy as their disease is considered fatal. Within a context of informal savings and credit organizations where perceived credit worthiness is key for accessing a loan, a guarantee mechanism can help to maintain access to credit for affected households, a mechanism which is already used by these organisations. However, such systems need to be designed very carefully, and lessons can be learned from micro finance programmes.

Local micro credit programmes in Benue State are also considering paying particular attention to HIV/AIDS in their work, partly through training and awareness-raising, but also by developing new products. In other countries, micro credit programmes have been initiated and are aimed at PLWHAs or their widows. On the one hand, such programmes are seldom sustainable as defaulting is common, because the advancing illness inhibits physical activity. It should be acknowledged that the operation of most Micro Financial Institutes (MFI) is based on self-selected credit groups, which employ strict criteria on eligibility and repayment. These groups are likely to exclude those people they consider as less creditworthy, putting the group's access to credit at risk.

Some experts argue that under circumstances of illness and death credit is not an option and may only increase the burden of debt for the credit taker, while also undermining the sustainability of the financial institution involved (Parker et al., 2000). However, MFIs in countries with high prevalence of AIDS (Southern Africa and in particular Uganda) start to develop workplace policies, risk management tools and discuss the development of new products, in particular loan insurance and savings products.

The existence of local insurance or social funds to cover the costs incurred through illness or burials can reduce the impact of morbidity and mortality on affected households. Some community organizations already have small funds for such events, but burial organizations do not appear to exist. Social capital is in fact the most important insurance.

In east and southern Africa, programmes have been started to improve access to sources of income for PLWHAs, sometimes also including their caregivers. The need is obvious but such endeavours are also faced with many challenges, precisely because the people involved have fragile health. The possibilities of food-for-work activities, in the short run, can be explored. Such programmes may help to prevent households from liquidating their asset base but will be less suitable for PLWHA (Kadiyala and Gillespie, 2003). Again, experiences with such special programmes should be analysed first. It is possible that well-designed, welfare-

oriented programmes are more appropriate to support PLWHA under these circumstances (UNAIDS, forthcoming).

Social protection for the poorest

HIV/AIDS will render some households destitute and may leave weaker members vulnerable such as orphans, elderly people and widows, having lost many of their assets. Some PLWHA will be too weak to work and their households may also have a reduced workforce or no more productive assets. These persons may end up becoming dependent on welfare and handouts. This will be a growing burden for communities and extended families, who in future may not be able to cope or no longer willing to provide support. It is important to start now with identifying ways for strengthening of existing safety nets internally, as well as with external support. An 'audit' of what already exists and how it really works in practice will be a first step.

Widows and orphans need better protection with respect to inheritance rights, which would render them much less vulnerable. Families can decide not to disinherit widows and protect the rights of orphans, and some do. In particular, community and religious leaders have a role to play in raising awareness on the implication of these practices and initiating protective measures. Family heads and other traditional and religious leaders have a great influence on the protection of the rights of PLWHA, their families, and the bereaved. They also have an influence on the issues surrounding stigma. However, these structures can just as easily become a source of vulnerability, when stigmatising PLWHA and denying care and support, for instance.

Regarding orphans, it is important to ensure that they are cared for as well as other children, go to school have access to health services etc. Not to do so, would create a new generation of very poor people, ill-equipped to earn a living. Family and community leaders have to ensure that someone takes responsibility for their care, that they can continue schooling, and are not subjected to stigmatisation, abuse and practices such as early marriage. Community leaders should also analyse how best to ensure transmission of vocational skills, given that so many of the PLWHA are traders, craftsmen etc.

Food aid can play a possible positive role in mitigating the impact of HIV/AIDS on the poorest members of the community (Bonnard, 2002; Kadiyala and Gillespie, 2003). Food aid needs to be delivered with caution in order not to undermine local food markets. Groups that should be considered are stunted children, pregnant and lactating women, impoverished female-headed households, households fostering many orphans and the elderly who have lost their children. Food supplementation for PLWHA needs to take their special requirements into consideration, and provide a diet to sustain energy and reinforce their immune system. Food aid needs to be delivered as part of an integrated package of services (income-generating activities, vocational skills training, asset replacement) and at the same time community participation must be strengthened in the design of food aid programmes. Targeting food aid to affected households or communities may be difficult due to stigmatisation.

10.7 Time is running out, but it is not too late yet

Policy makers in Benue State are aware of and concerned about the spread of HIV/AIDS, and the projected increase in number of HIV infections and a tripling of the number of AIDS deaths between 2001 and 2010. Diverting savings and investments into care and funerals will affect the economic development of Benue State. Losing so many young people undermines the fabric of society.

But, the impacts of the epidemic can still be mitigated. Nigeria in general, and Benue State in particular, have the advantage of being able to tap into lessons learned by other countries where the epidemic is more advanced. Moreover, resources are currently being made available to Benue State through many programmes.

Political will to act decisively to prevent the further spread of HIV and deal with the consequences of the epidemic exists. Although State, LGA, community and religious leaders do express concern with the AIDS epidemic, efforts on the ground are too limited. Local and state government, NGOs, have so far only reached certain parts of Benue. PLWHA organizations are found in a few places only. Too little has been done to support directly affected families and communities who are coping with the implications. First-line relatives with support of other members of the extended family are carrying the burden of care and support, and are coping with the consequences of illness and death. Community-level organizations contribute as they always have done and this is important. However, they are ill-prepared for growing demand and are not equipped to respond to the specific needs of PLWHA and AIDS-affected families.

The challenge for all actors is how best to support communities, organisations and households who are involved in prevention, eradication of stigma and are now giving care and support to PLWHAs. How best to support existing local safety networks so that they can become more effective without becoming overwhelmed, and how to sustain the productive and reproductive capacity of rural households in view of the demographic and socio-economic effects of the epidemic.

Support must build on local initiatives and existing safety nets, avoiding the development of external or parallel support systems, which cannot be sustained. PLWHAs and their organizations, their families, communities and leaders should be central in the development of action programmes. If effective action is taken now, the projected impoverishment and break down of livelihoods could partly be avoided.

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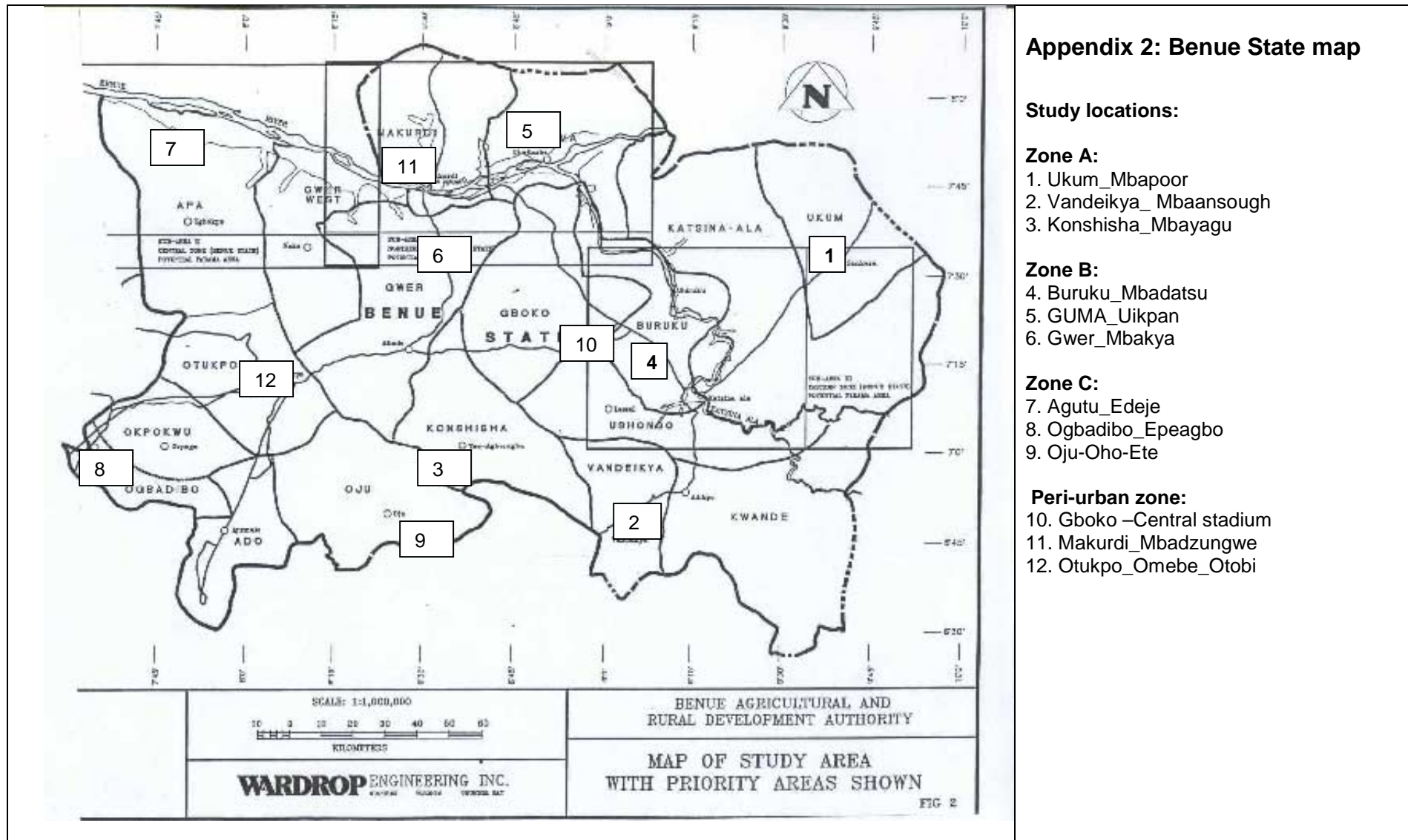
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Appendix 1: Overview of studies on the impact of HIV/AIDS on livelihoods and agriculture

Country	Year of publ.	Author	Size of study	Data collection methods	(proxy) indicator for HIV prevalence	Variables studied	Data analysis
Zimbabwe	1998	Kwaramba, P.	56 key informants 544 households with recorded deaths between 1992 – June 1997	Rapid appraisal Questionnaire	Death records (causes) interpreted by health technicians (clinically recorded signs such as excessive weight loss, persistent diarrhoea, TB resistant treatment, duration of illness, stomach complications, Carposi sarcoma, statements of victims)	Physical impact Economic impact Coping strategy Vulnerability households Cashing in on HIV/AIDS Expectations	Comparative impact analyses across agro-ecological zones, between provinces, between AIDS and non-AIDS case households (sign. tests)
Uganda	2001	Luzobe BN et al. (Winrock International)	246 respondents (officials, HIV/AIDS org., heads of households) of which 172 households	Household questionnaire FGD Interviews	Self-reported HIV/AIDS related death or illness	Production Roles and time allocation Access and control of productive resources Food and income Extension capacity building Coping strategies	Comparative analyses between affected and unaffected families (no sign. tests) Narratives
Kenya	2002	Yamano and Jayne	1422 small-scale households	Two surveys in 1997 and 2000	Prime-age adult mortality	Household size and composition Agricultural production Asset levels Off-farm income	Gendered difference –in-differences analyses between households with prime-age death and households without prime-age death Area-specific variant effects / status of deceased (sign tests)

Malawi	2002	Shah MK et al. (Care International)	310 households (2029 people)	FGD Household interviews	Chronic sickness	Livelihoods and agriculture production systems Kinship and institutional support Factors determining intensity of impact	Narratives Comparative analyses across districts, wealth categories, between affected and non-affected households (no sign. tests)
South-Africa	2002	Booyesen and Bachmann	Sample size unclear from the tables it is deducted to be about 258 ill individuals in 406 households	Interviews with the person responsible for daily organisation of the household	Households recruited from established networks and/or organisations involved in HIV/AIDS, and control households Continuously ill in the month preceding the interview Death in the six months preceding the interview	Burden of illness and death, caring Labour supply Income Expenditures Savings and debts Coping	Urban-rural Affected-non-affected Illness-no illness Death- no death Sign tests / multiple logistic regression
Swaziland	2002	Muwanga FT	456 subsistence farmers 92 private commercial farms, 10 government and nationalised farms, 16 cooperative societies	Questionnaire FGD Secondary data	AIDS related death of household member, by verbal autopsy / (validated by death certificate) determined by two independent clinicians	Health care costs Diversion of labor Mortality and morbidity / absenteeism Farm systems Cost impacts Production impacts Health seeking and financial behaviour Reponses Susceptibility and vulnerability Retirement Turnover / recruitment and training Employee benefits	Comparative analyses between households without deaths, AIDS-related death or non-AIDS death (sign. tests / OR)
Malawi	2003	Southern African	1st survey:	Food security	Presence of chronic illness	Proxy indicators	Compare proxy

Zambia Zimbabwe		Development Community, Food, Agriculture and Natural Resources Vulnerability Assessment Committee – SADC-FANR	2695 households: 2nd survey: 2652 households	assessments in August 2002 (3 countries) and December 2002 (only Malawi and Zambia)	or recent death (head household and adult members; Combination of the two; Presence of orphans; Dependency ratio; Number of adults between 18 and 59	Income and food purchasing power Food and cash crop production Coping strategies Food security outcomes (cereal gap)	households with non- proxy households for components of household food security (sign. tests)
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Annex 3: Local criteria for the different wealth categories

Criteria	Well-off	In-between	Poor
<i>Housing</i>	Zinc roof; well-built, maintained and furnished house, many houses including for reception	Zinc roof, no ceiling, not well furnished	Thatched roof, poorly maintained, limited space; no reception house; share house with animals
<i>Water / sanitation</i>	May own a well, & pit lavatory	Community well, streams	Community well, streams; Untidy environment
<i>Health care</i>	Can afford hospitals, orthodox treatments	Both orthodox and native	Relies on native treatment as less costly
<i>Education</i>	Children at school (primary and secondary)	Primary but seldom secondary school	Only primary school; Children often out of school
<i>Food security</i>	Food secure, can sell	Enough food	Food insecure
<i>Family size</i>	Many wives and children	2-3 wives	1 wife (finds it difficult to marry)
<i>Appearance of children</i>	Well-dressed, go to school; healthy	Adequately dressed	Poorly dressed, sometimes naked;
<i>Transport (also rented)*</i>	Owns vehicle or motorbike, many bicycles	Bicycle or motorbike	None or perhaps a bicycle
<i>Capacity to save</i>	Yes	Can save	No
<i>Access to loans</i>	Yes, but usually not necessary	Obtains loans easily	Limited, often in debt
<i>Membership in a bam or thrift society</i>	Heads a <i>bam</i>	Member	Not always a member
<i>Livestock</i>	Many heads	Medium	Few
<i>Orchards</i>	Large	Medium	No trees
<i>Size of fields</i>	Large	Medium	Small
<i>Farm investments</i>	Can invest in seeds, fertiliser, & labour; fields are well-maintained and work is done on time	Some seeds and fertiliser but not enough; work is done more or less on time	Not enough time to work on own farm; no capacity to invest; often late with farm operations; lower yields;
<i>Trading</i>	Large scale, bulk purchase; storage facilities	Medium	Petty (lacks capital)
<i>Use of labour</i>	Employs hired labour, some family labour too	Hired labour and family labour	Family labour only; husband; and family work as casual labourer for others
<i>Membership of cooperative</i>	Multipurpose cooperatives	Multipurpose cooperatives	Not a member
<i>Accommodating Dependants from elsewhere</i>	Many (contribute labour)	Few	Seldom (no means to look after them)
<i>Giving support to people in need</i>	Gives support to others regularly (and expected to do so)	Gives support	Depends on support of others
<i>Remittances</i>	From children and other relatives	Sometimes	None
<i>Other non-farming livelihood strategies</i>	Public service / pensions; transport; milling machines; political contacts	Use nets for fishing and guns for hunting	Casual labour; collect firewood (hunting, handicrafts uses common pool resources)

<i>Drinks</i>	Gulder, stout, or star	lager beer in green bottle	Local gin
<i>Appearance</i>	Looks healthy and well-dressed	Looks OK	Rags and dirty clothes
<i>Urbanised environments</i>	Telephone, video, TV	Motorcycle, radio	No farm; small living space, no electricity

* The relationship between poverty and the means of transport in a household varied from one community to another. In some communities, in-between households had motorbikes and the poor a bicycle; while in others only the well-off had motorbikes and the poor didn't even have bicycles.