Behavioural and Socio-Economic Implications of HIV/AIDS Patients on Population and Development of Ebonyi State

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ABSTRACT

HIV/AIDS has become one of the leading causes of death Worldwide since it was discovered over 30 years ago. The virus has defied permanent medical solutions and has continued to pose serious socio-economic challenges to Ebonyi state. This study investigated the behavioural pattern of HIV/AIDS patients in the state with a view to establishing its impact on population growth and economic development. The specific objectives are: to identify the behavioural pattern of HIV/AIDS patients in Ebonyi state; to establish the socio-economic impact of HIV/AIDS patients in Ebonyi state; to establish the impact HIV/AIDS has on population growth and economic development; and to recommend strategies for lowering the upsurge of HIV/AIDS epidemic in Ebonyi state. Federal Teaching Hospital, Abakaliki (FETHA) was selected for the study due to the strategic location of the institution and 210 HIV/AIDS patients were randomly sampled through simple random method. Descriptive method of data analysis was used. Findings revealed that 61.9% of those living with the virus are women, 76.2% have tertiary education, 71.9% are between 26 to 64 years old, 46.2% are single, 56.7% contracted it through sexual intercourse, 94.3% have been living with it for between 1 to 8 years, 71.4% engage in unprotected sexual intercourse since they contracted it and 85.3% are desirous of transmitting the virus to others before they die. Reported HIV/AIDS cases in the hospital between 2010 and 2014 were 2583. Causal and unprotected sexual intercourse, poverty, prostitution, indecent dressing, abuse of social network, non/improper use of condom among others were found to be some of the leading causes of the spread of HIV/AIDS in the state. The study recommends establishment of special task force to check indecent/offensive dressing, attitudinal/behavioural change/modification of the patients and control on the use of social network by the youth as measures to check the further spread of the virus in the state.

Key words: Behaviour, Socio-economic, Population, Development

Introduction

Human Immunodeficiency Virus (HIV) and the resultant disease, Acquired Immune Deficiency Syndrome (AIDS) are one of the greatest challenges affecting development and population growth all over the World. UNAIDS(2006) notes that those living with the virus have continued to increase and the upsurge can be traced to ignorance and poverty. It has reduced life expectancy by more than 20 years, slowed the growth rate of economy and population and increased household poverty (UNAIDS, 2006). It affects all regions of the world and reports show that about 1.9 million people were newly infected in 2008 in Sub-Saharan Africa. Federal Ministry of Health (FMOH) (2007) notes that according to the population survey, Nigeria's HIV prevalence is about 3.6%. Abasiubong, Udoh, Idung and Umoiyoho (2012) agree that sexual behaviour and attitude are important factors contributing to the upsurge of HIV and AIDS in developing countries especially Nigeria. However more worrisome is the fact that the behavioural activities and lifestyle of those living with the virus who are more often than not the distributive agents of this virus are often ignored. Varga (2001) observes that sexual attitudes and behaviours of the HIV/ AIDS patients are responsible for the ever rising rate of HIV/AIDS and other related sexually transmitted diseases (STD). Ijaiya, Usman, Ijaiya and Alabi (2007) reports that the greatest implications of HIV/AIDS are not just the associated ill-health of the patients but also the consequences for the social sectors and the economic development of the country. They equally noted that HIV/AIDS has led to the increase in morbidity and mortality and as a result, has created a development problem due to drastic fall in productivity of affected persons in particular and the country at large, increase in the cost of health care services, reduction in savings and capital accumulation, reduction in education funding and other developmental programmes of the economy, increase of orphans and orphanage homes with the attendant cost, high level of poverty, food insecurity, poor food quality and malnutrition arising from poor food quality.

In 2003, an estimated 1.8 million orphans were living with HIV/AIDS and in 2005, there was an increase of about 598,000 orphans and consequently, the cost of health care services provision through antiretroviral increased (Ijaiya et al, 2007). Other consequences of HIV/AIDS include increase in the infant mortality and the drop in the life expectancy of children at birth. In children under 5 years of age, HIV/AIDS are responsible for 7.7% of mortality world- wide (Tindyebera, Kayita, Musoke, Eley, Nduati and Coovadia, 2006).In Nigeria, the Federal Ministry of Health (2007) observes that the country accounts for 14% of total African burden on HIV/AIDS noting further that 90% of HIV/AIDS infection in children takes place through vertical transmission – from mother to child, sexual contacts, exposure to blood and blood products. Population Reference Bureau (PRB) (2008) explains that in Nigeria, infant mortality rate in 2007 was 100 per 1000 and life expectancy of 44 years. This according to the report is pathetic when compared with another less endowed African country, Morocco. In 2007, infant mortality rate in Morocco was 44 per 1000 and 70 years' life expectancy rate and this reflects the state of economic activities considering the per capita income of $1,770 as against $3,990 in Morocco.

Benson, Lauretta, Onyinye, Onuorah, Gildeon and Chioma (2014) agree that "the health care facilities represent a key point of contact with people living with HIV/AIDS, who are in need of prevention, treatment and support. In the same vein, Wanyenze, Ouma, Nawarru, Namale, Colebunder and Kamya (2010) and Ogunbosi, Oladokun, Brown and Osinusi (2011) submit that Provider Initiated Testing and Counselling (PITC) presents an opportunity to ensure that HIV/AIDS is systematically diagnosed in health facilities so as to establish the status and facilitate access to needed HIV/AIDS prevention, treatment, care and support. The Federal Ministry of Health (2005) estimates that about 5.4% of Nigerians are living with HIV/AIDS and this portends danger for a country with a population figure of approximately 150 million people. It is against this background that this study selected the Federal Teaching Hospital, Abakaliki (FETHA), Ebonyi state, Southeast, Nigeria as a study centre.

Abakaliki is the capital of Ebonyi state with an estimated population of 2,173,501 (www.nigeriamuse.com/wikipedia/2006 population census. The land mass of the state is 5,935 km2 with about 75% of the population dwelling in rural areas. Farming is their major occupation and the state is notable for the production of exportable high quality rice in Nigeria.

Objectives of the study

The broad objective of the study is to establish the behavioural and socio-economic implications of HIV/AIDS patients on population and economic development of Ebonyi state. The specific objectives are: (1) To identify the behavioural pattern of HIV/AIDS patients in Ebonyi state; (2) To establish the socio-economic impact of HIV/AIDS patients in Ebonyi state; (3) To establish the impact of HIV/AIDS on population growth and economic development; and (4) To recommend strategies for controlling the upsurge of HIV/AIDS epidemic in Ebonyi state.

Conceptual Definition and Literature Review

Acquired Immune Deficiency Syndrome (AIDS)

AIDS was first noticed in the United States (USA) in 1981 (Sharp and Hahn, 2001). Subsequent studies to establish the causative agent of human immunodeficiency virus type 1 (HIV – 1) showed that it was a retrovirus. Sharp and Hahn (2001) opine that as the strains of HIV – 1 were globally sampled, it was discovered that they exhibit extremely high genetic heterogeneity and that analysis of the evolution of this diversity gave insights into the pre-history of the virus. HIV-1 strains can be divided into three distinct groups with different prevalence. Groups 'N' and 'O' are not common and largely restricted to Cameroon and their surrounding countries (Sharp and Hahn 2001) while HIV-1 group 'M' causes about 98% of HIV infections world -wide. It may be important to note that within group 'M', there is very high diversity and the epicentre is in Africa particularly Kinshasa in the Democratic Republic of Congo (Vadal, 2000). Due to the fast rate of evolution of HIV-1 group 'M', the virus circulated within human populations for many before it was noticed.

When HIV-1 was first described, the closest known relative was visna, a virus from sheep that is the prototype member of the genus lent virus. Additional lent viruses were soon found in other primates, and a second virus (HIV-2) was found infecting humans. The virus from non-human primates were termed simian immunodeficiency virus (SIVs). Vadal (2000) notes that African green monkeys (chlorocebus specie) were among the first species to be found to be naturally infected. Over the past 30 years, the number of different SIVs identified has increased steadily; and currently, about 40 different primate species harbour SIVs. Researches show that SIVs are naturally found infecting primates in Sub-Saharan Africa. Where multiple strains of SIVs have been characterised from a single species, they generally form a monophyletic clad, indicating that the great majority of transmissions are intraspecific. The primate viruses as a whole, including HIV -1 and HIV-2, form a distinct clad within the lent viruses, indicating that humans acquired their infections from other primates,(Bailes,Chaudhuri, Santiago, Bibollet, Hahn and Sharp 2002). They point out further that psychogenetic analysis of these primates lent viruses have provided detailed insights into the evolutionary origins of the human viruses.

Hirsch, Olmsted, Murphy-Corb, Purcell and Johnson, (1989) submit that HIV-2 was first found among individuals from West Africa. In 1989, a closely related SIV was found in a monkey, the sooty mangabey (cercocebus atys), whose natural range is in West Africa.

Behaviour

Behaviour is a response of an individual to an action, environment, person or stimulus. Human behaviour is the capacity of mental, physical, emotional and social activities experienced during the five stages of human beings' life (pre-natal, infancy, childhood, adolescence and adulthood) (Kinicki and Kreitner 2003). Ivan Parlov in his work about understanding behaviour reveals that identifiable Stimulus – Response (S–R) condition reflexes are the basic elements of all behaviour (Luthans 1985). A stimulus elicits a behavioural response. Human behaviour is equally dictated by culture, society, values, moral, ethics and genetics.

Kiniki and Kreitner(2003) agree that behaviour involves self-monitoring and it is the degree to which a person observes his own self-expressive behaviour and adapts it to the demands of the situation. Luthans(1985) also state that "the key to understanding human mind was an understanding of how it functions and not only on how it is structured. In this functionalism approach, attention is shifted to the ability of people to adjust and adapt to their situation in the environment. He contends that to understand human mind, the total behaviour and experience of the individual must be established in addition to determining the interest in the adaptive functions.

Economic Development

Todaro and Smith(2011) posit that development is a process of "achieving sustained rates of growth of income per capita to enable a nation expand its output at a rate faster than the growth of its population". In other words, it captures how much of really goods and services are available to the masses for both consumption and investment. In a broader perspective, economic development is a planned alteration of the structure of production and employment aimed at enhancing and accelerating the growth of manufacturing and service sectors; focusing on rapid industrialisation strategies at the expense of agriculture and rural development. Duddley Seers (1996) as noted by Todaro and Smith (2011) observe that economic development must be conceptualised in terms of poverty, unemployment and inequality reduction; stressing further that "if all three (poverty, unemployment and inequality) have declined from high levels, then beyond doubts, there has been a period of development for the country concerned and that if one or two of these central problems have been growing worse, especially if all the three have, it would be strange to call the result "development" even if per capita income doubled". In contrary, Goulet (1971) as cited by Todaro and Smith (2011) argue that development is multidimensional involving major changes in social structure, popular attitudes, national institutions vis–a-vis economic growth acceleration, inequality reduction and poverty

eradication. Development means a change that moves away from unsatisfactory conditions of life toward a life regarded as materially better. In this context, sustenance, self-esteem and freedom are the basic conceptual components for understanding deeper meaning of development. They concluded on the premise that development is both physical reality and a state of mind of the society and must be based on the objectives of increasing the availability and widening the distribution of basic life sustaining goods; raising the levels of living standard with respect to higher income, more jobs; and expanding the economic and social choices available to all by freeing them from dependence.

Population and Economic Development

Globally, more than 75 million people are being added to the world's population yearly and 97% of this come from developing countries (Todaro and Smith, 2011). A major factor in population growth goes beyond mere numerical increase but the consequences on the well-being of the people, economic and social implications for development. If development involves recognition of the highlighted core values and objectives of development as well as improvement in the standards of living, rapid population growth must appreciate the need for corresponding rapid industrialisation.

Population Reference Bureau (2010)in Todaro and Smith(2011) observe that between1750 to 1950, 1.7 billion people were added to the world population and that in just four decades, 1950 to 1990, population doubled; bringing the total figure to 5.3 billion and 6 billion by year 2000 and a projected figure of 9.2 billion by 2050. Modern vaccination against malaria, polio, yellow fever, smallpox, cholera and a good number of public health facilities, provision of clean water, improved nutrition accounted for reduction of death rate (Population Reference Bureau, 2010). People under the age of 15 years according to Population Reference Bureau (2010) were more than 30% of the total population of developing countries as against 17% of developed countries. The Population Reference Bureau (2010) reports further that Ethiopia, Nigeria, Parkistan, both India and Mexico have 43%, 45%, 38% and 32% of their population under the age of 15 respectively. The youth dependency ratio to economically active ages (16 – 64 years) is very high in countries with such age structure and in this case, the support expected from the work-force in developing economies is almost double of the developed nations. Therefore, as the population grows rapidly, the greater the population of dependent children in the entire population and it poses a serious challenge to the working age to support the dependent children.

HIV/AIDS

Bonnel (2000) states that the spread of HIV/AIDS is associated with economic, social-cultural and epidemiological variables and that economic factor centres on labour migration, poverty, economic and gender inequality that expose the society especially the young youths to questionable behaviours that may lead to contracting the virus. Uneven development among nations and states, in the case of Nigeria, are now forcing people to change locations from rural to urban or less developed areas to developed/fast developing areas. The implication is detachment from loved ones thereby exposing them to casual/unprotected sex and other behaviours that may increase the risk of infection. Migration disrupted traditional values and favoured sexual promiscuity. Egerton (1938) reports that in the nascent cities, women felt liberated from rural tribal rules and it negatively affected their chances of getting married. Culture is the way of our life, the fundamental rights of the person, value system, traditions and beliefs that define a society (Conjoh, Zhou and Xiog2011). Some cultures belief that flesh to flesh sex enhances the masculinity of men and therefore condemns any sex practice that discourages flesh to flesh contact and this carries a high risk inflection. Pepin (2011) argues that the virus can be traced to a Central African bush hunter in 1921 where the Colonial mechanical personnel used improperly sterilized syringe and needles and continued to spread the virus silently in Africa for decades, fuelled by rapid urbanisation, prostitution and abuse of cultural values. Pepin, (2011) also claims that a Haitian teacherreturning from Zaire in the 1960s brought the virus to America. He claims that “sex tourism and contaminated blood transfusion centres eventually propelled AIDS to public consciousness in the 1980s and a world-wide pandemic". Ijaiya et al (2007) point out that in some parts of Asia, heterosexual contact is one of the ways through which HIV/AIDS spreads. Lamptey, Wigley, Carr and Collrymore, (2002) observe that epidemiological study carried out recently revealed that genital/anorectic ulcer disease and non-ulcerative Sexually Transmitted Diseases (STD) are important co-factors in the acquisition and transmission of HIVAIDS.

Consequences/ Implications of HIV/AIDS on the Society

Ainsworth and Over (1994) World Bank (1995, 1997), Robalino, Jenkins, El-Marrufi (2002) agree that the effect of HIV/AIDS can be grouped into two: the ones connected with increase in morbidity and mortality rates of the sexually active people. The effects on the increase in morbidity include decline in productive labour force due to the associated sickness and worry of being HIV positive, rise in health care spending and reduction in capital accumulation (savings). Reduction in savings and capital

accumulation directly affect investments on human development (education at different levels), reduction in physical structures and other areas that can propel national development and contribute to Gross Domestic Product (GDP).

HIV/AIDS induced mortality rate has demographic implications of negatively affecting population growth and create unfavourable age structure that can cause shortage of labour force at the long run. This has a multiplier effect on various sectors, especially industrial; because the demand and supply structure of goods and services are altered. Fluctuating figures of HIV/AIDS infected persons in the Ebonyistate indicates the need to evolve other strategies to curtail and control the spread of the deadly disease. Table 1 shows the number of HIV/AIDS patients who reported for counselling and treatment at the Federal Teaching Hospital, Abakaliki between January 1st 2010 and 31st December, 2014.

Table 1: Number of H IV/AIDS reported cases from 1 st January, 2010 to 31 st December, 2014

Gender/year	2010	2011	2012	2013	2014	Total
Male	150	138	307	188	133	916
Female	256	252	558	372	229	1667
Total	406	390	865	560	362	2583

Source: Field survey, 2015

Scope of the study

This study was carried out at the Federal Teaching HospitalAbakaliki, (FETHA)Ebonyi state. The major economic activity of the people is farming with specialisation in crops such as rice, yam, cassava, maize, sweet potato and other notable crops. A sizeable proportion of the population of the state lives in rural area/communities. FETHA is the only federal tertiary hospital in Ebonyi state, Southeast, Nigeria. It is situated in the state capital along Enugu – Abakaliki road and provides health care services for the people of the state and people from neighbouring states of Enugu, Cross River and Benue. It receives referrals from all parts of the state and beyond. The strategic location of the hospital informed the choice of the hospital for the study.

Sample and Sampling Procedure

The Federal Teaching Hospital (FETHA) Abakaliki was purposively selected for the study. Two hundred and fifty (250) questionnaires were distributed to patients living with HIV/AIDS through the aid of health personnel working in the unit. The centre/unit designated for counselling and distribution of antiretroviral drugs to HIV/AIDS patients is called Communicable Control Disease and Research Unit (CCDRU). Data was obtained through secondary and primary sources. Data from primary sources were sought for with the aid of structured questionnaires administered strictly to only those living with the virus.

Analytical Techniques

Two hundred and fifty (250) questionnaires were distributed and only two hundred and ten (210) were properly completed and recovered. This is 84% and 16% response and non-response rates respectively. Descriptive statistics like percentile was used in determining the socio-demographic characteristics of respondents and other specific objectives of the study. In depth interview was also carried out to establish the authenticity of results/responses obtained from the administered questionnaires.

Table 2: Determination of the demographic characteristics of HIV/AIDS Patients in Ebonyi State

S/n	Items	Responses	Frequency	Percentage
1	Gender	Male	80	38.1
		Female	130	61.9
	Total		210	100
2	Educational level	Tertiary Institution	160	76.2
		Secondary School	30	14.3
		Primary School	20	9.5

	Total		210	100
3	Age	Below 25	25	11.9
		26 – 45	70	33.3
		46 – 64	81	38.6
		65 and above	34	16.2
	Total		210	100
4	Marital Status	Married	24	11.4
		Single	97	46.2
		Widowed	63	30.0
		Divorced	26	12.4
	Total		210	100
5	Occupation	Trading/self employed	60	28.6
		Civil Servant	45	21.4
		Unemployed/students	105	50.0
	Total		210	100

Source: Field survey, 2015

Table 3: Determination of how the virus was detected

S/n	Items	Responses	Frequency	Percentage
1	How did you contact the virus?	Sexual intercourse	119	56.7
		Blood Transfusion	31	14.7
		Sharing of unsterilized sharp objects	26	12.4
		Mother to ch ild during pregnancy/breast feeding	24	11.4
		Barbing saloon	10	04.8
	Total		210	100
2	For how long have you been living with the virus?	1 – 4 years	154	73.3
		5 – 8 years	44	21.0
		More than 9 years	12	05.7
	Total		210	100
3	How was the virus discovered?	Routine check-up	65	31
		When I took ill	136	64.8
		When I wanted to donate blood	09	04.2
	Total		210	100
4	Have you had any unprotected sexual intercourse since infected?	Yes	150	71.4
		No	60	28.6
	Total		210	100
5	What effort are you making to check the spread of the virus?	No effort	47	22.4
		Somebody gave me, I must give as many as possible before I die		
		I have stopped having sex	132	62.9
		I organise talks for the youths on AIDS	21	10.0
			10	04.7
	Total		210	100

Source: Field survey, 2015

Table 4: Determination of the socio -economic impact of HIV/AIDS on economic development of Ebonyi state

S/n	Items	Responses	Frequency	Percentage
1	Is your productivity negatively affected by this health challenge?	Yes No	169 41	80.5 19.5
	Total		210	100
2	If your answer to ‘’1” above is yes, why are you negatively affected when antiretroviral drug is there to support you	The drug is not curative Why working when I will eventually die of th e sickness I hate everything around me I am preoccupied thinking of how I got it rather than working/being productive	41 115 30 24	19.5 54.8 14.3 11.4
	Total		210	100
3	Do you feel HIV/AIDS patients are increasing since you started co ming for counselling and treatment?	Yes No	177 33	84.3 15.7
	Total		210	100
4	What is responsible for the increase if your response to question `3` is yes?	Poor Govt policy Behavioural attitudes of the patients Availability of prostitute	65 95 50	31 45.2 23.8
	Total		210	100
5	What measures do you think can be put in place to check the increase of HIV/AIDS patients	Enforceable law against indecent dressing Control on the usage of social network on our phones Ban of prostitution Free distribu tion of condoms Engaging the youths/creation of jobs	 54 62 50 14 30	 25.7 29.5 23.8 06.7 14.1
	Total		210	100

Source: Field survey, 2015

Results and Discussion of Findings

Table 1 shows that between 2010 and 2014, a total of 2583 HIV/AIDS cases were reported at the Federal Teaching Hospital, Abakaliki. Table2indicates that approximately 62% of HIV/AIDS patients in Ebonyi state are female while 38% are males implying that if the spread is not controlled, the state may witness a sharp drop in birth rate and by extension, the population. 76% have tertiary education while 14.3% and 9.5% of the patients sampled had

secondary and primary educationrespectively. Education plays pivotal role in the development and socio-economic well-being of a society and therefore the productivity of the state may start declining. Responses obtained on the same table showed that 71.9%, 16.2% and 11.9% of those between the ages of 26 to 64 years, above 65 years and below 25 years respectively have the virus. This finding indicates that the productive age is more affected and this may lead to multiple challenges on the economic growth of the state. The analysis of marital status of those living with the virus shows that 11.4%, 46.2%, 30% and 12.4% are married, single, widowed and divorced respectively. On the same table, 50%, 28.6% and 21.4% of the respondents living with the virus are unemployed/students, traders/self-employed and civil servants respectively.

Table 3 shows that 56.7% contracted the disease through sexual intercourse, 14.7% through blood transfusion, 12.4% through unsterilized sharp objects, 11.4% through mother to child and 4.8% from barbing saloon. Responses obtained indicate that 73.4% have lived with the virus for 4 years, 21% between 5 to 8 years and 5.7% above 9 years. On how it was detected, 64.8% knew their status when they fell sick and was tested, 31% through routine health check-up and 4.2% when they wanted to donate blood.

On their sex behaviour since they became positive, 71.4% of the respondents have had unprotected sex since they contracted it while 28.6% have not. On their effort to check the spread, 62.9% opined that they desire to distribute the virus to as many as possible because someone passed it on to them, 22.4% said that they are not making any effort at all while 10% and 4.7% said that they have stopped having sex and organise talks for the youths on the dangers of HIV/AIDS in that order.

Responses on table 4 show that 80.5% of the respondents agreed that the virus is negatively affecting their productivity. On the reasons why they are negatively affected, 54.8% of the respondents felt that it was fruitless working since he/she will eventually die of the disease. 19.5%, 14.3% and 11.4% said that they are negatively affected because the antiretroviral drug is not curative, feeling of irritation of everything around him/her and always pre-occupied thinking about how he/she contracted the deadly disease.

On whether HIV/AIDS patients are increasing, 84.3% said yes while 15.7% disagreed and their reactions on what may be responsible for the increase, 45.2% of the respondents attributed it to the behavioural attitudes of the patients while 31% and 23.8% blamed poor government policy and rising cases of prostitution occasioned by hardship respectively. How measures can be put in place to check the spread of the virus, 29.5% suggested the introduction of control measures on social networks to check the excessive application of this by the youth mainly. 25.7%, 23.8%, 14.1% and 6.7% agreed that stringent and appropriate laws should be enacted to control indecent dressing, banning of prostitution, job creation/youth empowerment for the unemployed and free access to condoms respectively.

Implications on the Findings

The results highlighted indicate that 130(62%) of HIV/AIDS in the state are female and that 119(56.7%) contracted the virus through sexual intercourse. The implication of this trend is that most of these women may not be married and even if they are, they may not have their desired number of children. The long-run effect of this is a drop in population and more dependants/orphans. This is in tandem with the findings of the Population Reference Bureau (2008) that 45% of Nigeria's population are under the ages of 15 and this challenges economic development due to pressure on the working age to support the dependants.

On controlling the spread of the virus, the results obtained showed that 179(85.3%) of the sampled population were not interested in checking the rising rate of HIV/AIDS in the state. Their behaviour is in response to their emotions and stimulus. They are emotionally attached to the fact that they contracted it through someone and therefore try to adapt their behaviour to the demands of the situation. This supports the findings of Kiniki and Kreitner (2003)that behaviour is the degree to which a person observes his/her own self-expressive behaviour and adapts it to the demands of the situation.

From the results obtained, 80.5% of the respondents agreed that their productivities are negatively affected because of their HIV/AIDS status. This discovery according to 54.8% of the respondents is associated with the belief that they will eventually die of the disease and therefore do not have any need for being productive. The socio-economic implications of this are increase in poverty, increase in inequality and slow/poor economic growth rate. This finding supports the submission of Sears (1996) who noted that economic development must be seen in terms of poverty, unemployment and inequality reduction. From their reactions, 177(84.3%) agreed that since they started coming for counselling and treatment, the

number of infected persons have continued to increase noting that the activitiesof prostitutes/commercial sex workers as a factor. In a developing economy, prostitution is common and it is a situation where women engage in indiscriminate sex for economic considerations and stigmatisation forces the illicit trade to attract cross border/state/city/town migration. This agrees with the findings of Bonnel (2000) that the spread of HIV/AIDS is connected with economic factor aimed at poverty reduction among others.

Recommendations

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

The patients should be sensitized on the need for behavioural/attitudinal change in the struggle to control the spread of the virus. This is very important at least to save the productive age as findings indicate that 72% of those living with the virus are between the ages of 26 to 64. This may require formation of Special Task Force to arrest and prosecute the indecently dressed in the society. For instance, Osun State Government constituted a Special Military Task Force called Swift Action Squad (SAS) to curtail crime and indecent dressing in the state. This should be nationally embraced A situation where women expose offensive parts of their body to create attention should be outlawed. This practice is much more common in institutions of higher learning as findings show that 76.2% of the respondents living with HIV/AIDS are either in tertiary institutions or have passed through them.

Sexual intercourse is natural in human, therefore government should, on regular basis organise sensitization programme on the need to use condom, abstinence if possible or adherance to one sex partner. Once this behavioural change is imbibed, it will generate positive working habit that will raise productivity.

Concerted efforts are required to ensure that even those affected can give birth to their desired number of children to sustain population growth and development since a greater percentage of those victims were women. Application of social network should be closely monitored by the governments to minimise importation of foreign/alien cultures.

Conclusion

In conclusion, this study has examined various factors responsible for HIV/AIDS infection in the Ebonyi state and noted that there is a steady increase of HIV/AIDS infected persons and this trend portends danger for population growth and economic development. Evidence showed that women are more vulnerable to HIV/AIDS infection and therefore sustenance of campaign for behavioural change, behaviour modification, use of condom, abstinence and adherence to one sex partner become imperative since there is a strong association between unprotected sexual intercourse and HIV/AIDS infection.

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