SOCIO-ECONOMIC IMPACTS OF HIV/AIDS ON THE OLDER PERSONS AND THEIR COPING STRATEGIES IN SOMOLU LOCAL GOVERNMENT AREA OF LAGOS STATE

AJIBOYE, OLANREWAJU EMMANUEL (Ph.D)
Department of Sociology, Faculty of Social Sciences,
Lagos State University, Ojo, Lagos
oeajiboye@yahoo.com; 2348034093309

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CLEMENT OLAOSHEBIKAN CANDIDO
Master of Social Work, Department of Sociology, Faculty of Social Sciences
Lagos State University, Ojo

Abstract
The proportion of older people is increasing worldwide. Globally, it is estimated that older persons (those 60 years or older) constitute more than 11% of the world population. As the HIV/AIDS pandemic rages in sub-Saharan Africa, its impact on older persons needs closer attention given the increased economic and social roles older persons have taken on as a result of increased mortality among adults in the productive age groups. HIV may affect older persons in a number of ways. They may become infected themselves; their children may suffer prolonged illness and incapacity, and need older persons to look after them; the same children may then die from the illness, leaving the older persons without the support of the next generation; the bereavement also leaves the older persons to meet funeral costs and then to take care of orphans left behind. HIV has impacts on old people in ways that are social, economic, psychological and physical in nature. Few studies have looked at older persons and their health in Somolu Local Government Area and indeed the impact of HIV/AIDS on their health. This study aims to examine the dilemma of the older persons infected and affected by HIV/AIDS in Somolu Local Government Area of Lagos State and their coping mechanism. Purposive sampling technique was used to identify persons over 60 years and above who are infected or affected with HIV/AIDS. The data collected were analyzed using appropriate descriptive qualitative analysis techniques. The study found that there is a deepening impact of HIV infection and disease on the older population in Somolu Local Government Area of Lagos State despite the availability of Anti-retroviral drugs from the Government hospitals and Non-Governmental Actors.

KEY WORDS: Impact, HIV/AIDS, Older Persons, Well being, and Anti-retroviral.

Introduction
Global populations of all age groups have grown substantially. The World population stood at 7,300,332,237 billion as at March 2015 having passed the 7 billion mark in 2011. Developing countries accounted for about 97 percent of this growth because of the dual effects of high birth rates and young populations. For instance, Nigeria population stood at 182,052,028 million at an annual growth rate of 2.8% and this is predicted to continue to the coming years.

Conversely, in the developed countries the annual number of births barely exceeds deaths because of low birth rates and much older populations. By 2025, it is likely that deaths will exceed births in the developed countries, the first time this will have happened in history. While virtually all future population growth will be in developing countries, the poorest of these countries will see the greatest percentage increase. As defined by the United Nations, these 48 countries have especially low incomes, high economic vulnerability, and poor human development indicators such as low life expectancy at birth, very low per capita income, and low levels of education. Of these countries, 33 are in sub-Saharan Africa, such as Burundi, Ethiopia, Mozambique, and Zambia; 14 in Asia, including Bangladesh, Cambodia, Nepal, and Yemen; and one in the Caribbean, Haiti. They are growing at 2.4 percent per year and are projected to reach at least 2 billion by 2050 (World Population Data Sheet, 2012).

It has been observed also that, the largest regional percentage increase in population by 2050 will be in Africa, whose population can be expected to at least double from 1.1 billion to about 2.3 billion. That projection, however, depends on the assumption that sub-Saharan Africa’s total fertility rate (TFR, the average number of children per woman) will decline from 5.1 to approximately 3.0 by 2050. That decline,
in turn, assumes that the use of family planning in the region will rise significantly. But recent surveys from many sub-Saharan African countries have indicated that TFR decline is either slower than projected or is not taking place at all. Only 20 percent of married women in sub-Saharan Africa use a modern form of family planning, the lowest rate in the world (World Population Data Sheet, 2012).

The proportion of older people is increasing worldwide. It is estimated that older people (those 60 years or older) constitute more than 15% of the population globally, over 25% of the population in developed nations and about 11% in developing ones. The proportion of older people in developing countries is expected to rise to about 25% by 2050. Older people therefore will increasingly form an important subgroup in numeric terms in developing nations (United Nations, 2007; UNDESA, 2009).

The most significant feature of the ageing of the population is the increased speed with which ageing will occur in developing countries compared with the earlier experience of the developed countries (Amanda, 1999; Schoenmaeckers 2007; UNDESA, 2009). For example, Africa will experience a faster growth in the number of older people in its population by 2050 than other regions of the world. The number of people aged 60 years and over in Africa is projected to increase from the 2009 figures of 53.7 million to 64.5 million in 2015, which is also the target date for achieving MDGs and increase to 212 million by 2050 (The World Population Prospects 2008 Revision). This represents an increase rate twice the annual population growth rate, with the number of older people in the population increasing at an annual rate of 3.1% between 2001 and 2015, and 3.3% between 2015 and 2050 (UNDESA, 2007; 2009). Globally, ageing populations present a challenge to all regions of the world.

Africa is often referred to as a ‘young continent’ in terms of age structure. This description may have contributed to the current relatively low prioritization of ageing issues in national policies (UNDESA, 2007; 2009). However, the age structure of Africa is changing dramatically and the continent will experience the fastest rate of growth in the numbers of older people in the population than any other continent in projections by 2050 (UNDESA, 2007; 2009). For instance, in 1950 the numbers of people aged 60 years and over was approximately 12 million in Africa and by 2007 this number had increased to about 50.5 million people. By 2030 there will be 103 million older people and the number of older people is projected to rise to 312 million by 2050. The figures represent an exponential increase in the numbers of older people across Africa (UNDESA 2007; 2009). The above figures highlight the rapid rate of change and the need for immediate policy action on older persons in Africa at large and in Nigeria in particular.

In terms of proportion of the total population of Africa, the percentage of people aged 60 and over increased from 4.9% to 5.3% between 1950 and 2005. This proportion will increase to 5.6% by 2015, 6.8% by 2030 and rise to 10.4% by 2050. The reality is that older people will make up an increasingly significant share of the population in Africa (World Population Prospects: The 2006 Revision). When the summary of the figures for the whole of Africa were disaggregated these revealed demographic variations between countries and sub-regions. The majority of older people in Africa live in Northern Africa, Eastern Africa and Western Africa, which are the most populated regions in the continent. In contrast, only a small proportion of older people live in Middle Africa and Southern Africa. The rate of increase differs between regions, countries on the continent. Northern Africa and Southern Africa are the most rapidly ageing regions in the continent. In 2009 older people made up 7.0% and 7.0% of the population of these two regions respectively. Projections indicate that older people in Northern Africa will increase rapidly to 8.2% by 2015, 11.9% by 2030 and 19.6% of the population by 2050. Southern Africa is also projected to experience a relatively rapid increase but at a slower rate. The remaining three regions of Eastern Africa, Middle Africa, and Western Africa follow a similar pattern of slow increase in older people as a proportion of the total population. By 2015 older people will represent between 4.3% and 5.1% of the total population in these three regions. This will increase slightly to between 4.6% and 6.0% by 2030, and the older proportions are projected to rise to between 6.7% and 9.3% by 2050 (Blommesteijn, H; De Jong Gierveld, M. and De Valk, 2003; UNDESA, 2009).

At the country level, there are also considerable variations in the rates of population ageing in Africa. The population is ageing rapidly in Mauritius, Tunisia, Algeria, Egypt, Morocco and Libya. In 2005 older population aged 60 years and over constituted 8.7% in Tunisia and 10% of the population in Mauritius. These percentages are forecast to increase to 10.4% and 13.3% respectively by 2015, and rise to 16.8% and 20.9% respectively by 2030. In Sub-Saharan Africa, other countries experiencing rapid rates of ageing include Gabon, Djibouti, Nigeria, Cape Verde, Gambia, Ghana, Togo, and Senegal, while the remaining countries have slow rates of increase in the percentage of older people in the total population. At the same time these countries are experiencing a rapid decline in fertility and increasing survival rates across all age groups (Bloom David E., Canning David M., and Michael J. 2004).
Another distinct population ageing pattern is evident in those countries hardest hit by the HIV/AIDS pandemic (Botswana, Namibia, Lesotho, South Africa, Swaziland, Zimbabwe and Zambia). These countries are experiencing high death rates as a result of HIV/AIDS, particularly among the sexually active age groups and a concurrent decline in fertility rates. The mortality rate is therefore a major factor in these countries impacting on the age structure of their populations (Blomme et al 2003; Schoenmaeckers 2007). By 2020, this share is expected to increase to 70 percent of older persons and because of higher male mortality rates, females predominate at older ages and the discrepancy between sexes becomes greater with advancing age. This trend will result in a large proportion of older women spending many years without partners (Leete, 1998; Unanka, 2002; Zuberi, 2006; UN, 2007).

Older people have traditionally been held in high esteem in many African societies for their wisdom, role as heads of families, and roles in conflict resolution. Some authors have used the term "gerontocracy" to illustrate the powerful position older people hold in most African societies in. More recently, older people have been engaged in the fight against HIV/AIDS especially in their role as caregivers for HIV infected family members and orphans left behind by deceased relatives. The vulnerability of older people as a consequence of the HIV/AIDS epidemic has increased due to the weakening of traditional social support structures, increased mortality of family members in the productive age group and subsequent loss of economic support for older people. In many cases the death of an adult in the reproductive age group is soon followed by the death of the spouse leaving behind a number of orphans. It is estimated that up to 60% of orphaned children live in grandparent-headed households in some SSA countries.

The HIV/AIDS pandemic caught the world unawares with its ravaging effects. It succeeded in re-defining the structure of the family in several parts of the world, particularly in Sub-Saharan Africa. The proportion of HIV-infected older people has increased in recent years in developed countries where the use of antiretroviral therapy is widespread but there are indications that this is also the case in some African countries. In Kenya, it is estimated that 5% of those infected with HIV/AIDS are aged 50 years and older and recent research and public health discourses are increasingly highlighting the need to focus on older people in the fight against HIV/AIDS. As the HIV/AIDS pandemic rages in sub-Saharan Africa, its impact on older people needs closer attention because the intersection of the HIV/AIDS pandemic and population aging in Sub-Saharan Africa may have far reaching consequences on societies’ economic, social and political spheres of life. Despite this evident need, issues of aging in Africa have only recently started receiving attention in research and in policies. There is a near absence of policies and programs targeting older people in most countries in Sub-Saharan Africa and most health policies are geared towards the needs of traditionally vulnerable groups of women and children.

The impact of the HIV/AIDS pandemic on other age groups such as young children, adolescents and adults in reproductive age has been extensively studied. There are few studies on older people in Sub-Saharan Africa in general and their health in particular. It is therefore unsurprising that not much is known about the impact of HIV/AIDS on their health. Studies on the impact of HIV/AIDS on older people have focused on quantifying the extent to which older people are involved in care giving roles, the economic impact of the loss of adult family members, and the impact of HIV/AIDS on traditional social support networks in the African context including disruptions in living arrangements. Some studies have also looked at the multidimensional and indirect effects of HIV/AIDS on older people, including the health consequences of care giving roles though not in great detail. The few studies that have assessed the impact of HIV/AIDS on the health and wellbeing of older people have predominantly focused on the indirect effect of HIV/AIDS and have found that it has negative consequences on the health of older people. A study in Zimbabwe found that only 30% of older people affected by HIV/AIDS reported being in good or very good health and of those in bad or very bad health, 58% attributed it to providing care to AIDS-affected family members. In Uganda, a study on older caregivers found that most respondents had anxiety about their future and wellbeing and that most, especially females, had physical ailments. Similar findings were found in Thailand among older people that were caring for adult children with AIDS, although respondents were only asked about pre-determined health conditions. They reported more anxiety, more insomnia, less happiness than those who were not looking after adult children with HIV/AIDS. They also reported relatively high fatigue, muscle strain, headache and stomachaches.

The first two cases of HIV/AIDS in Nigeria were identified in 1985 and were reported at an International AIDS conference in 1986. In 1987, the Nigerian health sector established the National AIDS Advisory Committee which was shortly followed by the establishment of the National Expert Advisory Committee on AIDS (NEACA), (UNDP Report, 2009). Despite being the largest oil producer in Africa and the 12th largest in the World, Nigeria is ranked 158 out of 177 on the United National Development Programme.
(UNDP) Human Poverty Index. This poor development position has meant that Nigeria is faced with huge challenges in fighting its HIV and AIDS epidemic. Arguably, one of the biggest drivers of the pandemic in Sub-Saharan African at large and in Nigeria particular is the poverty level of the people. It is estimated that about 4.6million people are living with HIV/AIDS in Nigeria (National Agency for the Control of AIDS sentinel survey, 2010), and more than 60% of the new HIV cases occur among rural settings (UNFPA, 2007). It should be mentioned at this juncture therefore that, since the detection of the HIV/AIDS in Nigeria, it has created a huge future problem for Nigeria by turning out large number of infected and affected segments of the older population.

This study therefore aims to fill existing knowledge gaps on the impact of HIV/AIDS on the health of older people in Somolu Local Government Area of Lagos State. It assesses the direct and indirect effects of HIV/AIDS on the health of older people in the study location in a quantitative manner using standard measures of health and considering other dimensions in which older people can be affected by HIV/AIDS. The study also aims at drawing attention of all stakeholders to the dilemma of the increased number of older persons infected and affected in Lagos State in general and Somolu Local Government Area in particular. It hopes to examine the perception of the older persons in the study area to HIV/AIDS pandemic, their coping mechanism and also the overall impact of the infection on their physical, economic, and psychological wellbeing. Finally, the study will endeavour to assess the management control measures put in place by both the government and non-governmental agencies in assisting the older persons living with HIV/AIDS in Somolu Local Government Area of Lagos State.

Problem Identified

The HIV/AIDS pandemic is a serious challenge threatening the minimal developmental achievements of Nigeria and that of the entire African continent in general. This is because the African population in general and Nigerian in particular is not only the most vulnerable but also the least capable of confronting the magnitude of the problem, since it was first noticed in early 80s in Nigeria, reveal that its prevalence has been consistently on the increase. Nigeria has an estimated adult prevalence of 6.5 percent as at 2012, but with over 160 million inhabitants.

It is further estimated that presently Africa’s aged population is about 36.6million and this is expected to rise to 215 million by 2050 (UNHCHR, 2011; UNAIDS, 2012) This projection present a gloomy picture for the future of Africa and Nigeria which happens to be the largest country in the continent, not because it is anathema to age, but because it is apparent that adequate policies are not in place to cushion the effects of the emerging phenomena. Evidences and Researches have shown that about 62% of the world’s HIV cases occurred in Sub-Saharan Africa. It should also be mentioned that more than 14,000 people are daily infected with the HIV and about 11,000 people are dying daily due to HIV/AIDS related illness with its grave socio-concomitant effects on the infected and affected individuals.

Today, a growing number of older people now have HIV/AIDS. Almost one-fourth of all people with HIV/AIDS in this country are age 50 and older. This is because doctors are finding HIV more often than ever before in older people and because improved treatments are helping people with the disease live longer. Anyone facing a serious disease like HIV/AIDS may become very depressed. This is a special problem for older people, who may not have a strong network of friends or family who can help. At the same time, they also may be coping with other diseases common to aging such as high blood pressure, diabetes, or heart problems. As the HIV/AIDS gets worse, many will need help getting around and caring for themselves. Older people with HIV/AIDS need support and understanding from their doctors, family, and friends.

HIV/AIDS can affect older people in yet another way. Many younger people who are infected turn to their parents and grandparents for financial support and nursing care. Older people who are not themselves infected by the virus may find they have to care for their own children with HIV/AIDS and then sometimes for their orphaned or HIV-infected grandchildren. Taking care of others can be mentally, physically, and financially draining. This is especially true for older caregivers.

Put differently, Older persons are donning the toga of active home makers once again as most of these have had to stand in the gap for their HIV infected children, who have either become too weak and sickly to take care of their children, or have died due to the infections. The problem becomes even worse when older caregivers have AIDS or other serious health problems.
Purpose of the study
The purpose of this study is to examine the situation of older people affected by HIV/AIDS and to assess the adequacy of strategies adopted to address their needs, with a view to making appropriate recommendations. The population of older people living with HIV in Lagos State stood at 223,425 (NBS, 2008), though, figures look small in comparison with the population of older persons in Lagos State, it is however traumatic when measure the untold hardship it has on the individual and the society at large.
In order to effectively accomplish this, the following research questions need to be answered:

- What is the situation of older people affected by HIV/AIDS in Shomolu Local Government in Lagos State?
- What roles are extended family members and organized bodies playing in meeting the needs of affected older people?
- To what extent are these activities successful and what constraints are being faced?
- How can assistance be routed to reach appropriate groups?

Research Objectives
Having said the foregoing therefore, the broad objective of this study is to determine how the situation and the needs of the older people affected by HIV/AIDS can be appropriately met. Specifically, the study seeks to:

- Examine the situation of older persons affected by HIV/AIDS and establish their needs in Somolu Local Government Area of Lagos State;
- Assess the capacity of family structures to cope with the problem of older people affected by HIV/AIDS in Somolu Local Government Area of Lagos State;
- Determine the extent to which the assistance receive by the victims has helped in their coping ability;
- Examine the various family and other organized agencies responses to the needs of vulnerable older people in Somolu Local Government Area of Lagos State.

Scope of the study
This study examines the impact of HIV/AIDS pandemic on the aged population in Somolu Local Government Area. The choice of Somolu Local Government Area was premised on its significant location between two high density areas namely Yaba and Bariga. Another reason for the choice of the study area has to do with its relatively high numbers of older persons in the State.

Methodology
This study, which is a pilot study and mainly descriptive in nature, was carried out in Somolu Local Government Area of Lagos State. A non probability sampling technique was used in the identification of the study populations. The choice of this method may not be unconnected with the nature of the study. Secondly, attempt to use other sampling technique such as probability sampling technique would require a larger sample size of HIV/AIDS infected or affected adults (using the prevalence rate of 6.0 and a 95 per cent confidence interval), which may not be achievable with the nature and type of this study.

Sample Design and Size.
Due to the nature of the research and the difficulty in indentifying people infected and affected with HIV/AIDS without contravening the anti-discrimination laws of Lagos State, purposive sampling technique was used to identify persons aged 55 years of age and above who are either infected or affected by HIV/AIDS in Somolu Local Government Area. This process was facilitated by the researcher’s skill and prior knowledge in conjunction with the Support Group of the People Living with HIV within the same Local Government Area. The support of HOPE Worldwide Nigeria, a non-governmental organization whose activities include the care and support for those living with HIV in the area was also commendable. Respondents were drawn from the identified Older Persons infected or affected with HIV in Somolu Local Government Area with the assistance of the Support Group in the area including HOPE Worldwide Nigeria who are ever ready and willing to participate in the study. The study originally planned to sample Fifty (50) respondents, however, a total of twenty-three (23) either infected or affected older persons were eventually sampled and interviewed for the study, using an In-depth interview method of data collection.
Data Interpretation and Analysis

There are several methods that can be used in analyzing the data collected, however, for the purpose of this study the data collected were analyzed using appropriate descriptive qualitative analysis technique. These include both ethnographic and content analysis methods.

### Percentage Distribution of Respondents Socio-Demographic Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>60.9</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 60</td>
<td>13</td>
<td>56.2</td>
</tr>
<tr>
<td>60 – 69</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td>70 – 79</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>80+</td>
<td>1</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Ethnic Affiliation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoruba</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>Igbo</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Hausa</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Others (Edo, Itsekiri, Benue, etc)</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td><strong>Religion Affiliation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>Islam</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>Widowed/Widower</td>
<td>14</td>
<td>60.9</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently Working</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td>Not Working</td>
<td>16</td>
<td>69.6</td>
</tr>
<tr>
<td><strong>Nature of Primary Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artisan</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>Trading/Business</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Civil Servant</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Private Worker</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td>Commercial Driver</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td>Religion Work</td>
<td>1</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: Field Survey, 2014

Socio-Demographic characteristics are useful determinants of the status of the respondents included in any social survey and they are also indicators of the socio-economic status of households. The socio-demographic characteristics of our respondents are presented in the above table. The table revealed that more males were included in the sample with a total of 60.9% of the total respondents while the remaining 39.1% were female. When the question on the age of the respondents was analyzed, the table further revealed that, those who fell within age bracket below 60 years are in majority with 56.2. This was followed with age bracket 60 – 69 with 30.4%; age bracket 70 – 79 and 80 and above had 8.7% and 4.4% respondents respectively.

Effort was made to find out the part of the country where our various respondents come from. As expected, Yoruba were in majority, this may not be unconnected with the fact that the study was conducted in a Yoruba dominated environment. The table therefore revealed that Yoruba has 39.1%; followed by those who claimed others with 34.8%, while Igbo and Hausa recorded 17.4% and 8.7% respectively. The inquiry into the religion affiliation of the respondents indicated that Muslim were in majority with 39.1%, followed by those who claimed others with 34.8% and Christianity recorded 26.1% of the total sample population.
60.9% of the respondents were either widow or widower, while 39.1% of the total respondents still live with either spouse.

Finally, analysis of the job status and the primary occupation of our respondents revealed that, 69.6% of the respondents are not currently working, while about 30.4% claimed they still do one or two things for livelihood. The table further indicated that 39.1% were artisan, 21.7% were commercial drivers, 17.4% were either engage in trading activities or business transaction, those who worked with private organization and civil servant had 8.7% and 8.7% respondents respectively while respondents who engaged in religious activities had the least responses of 4.4% of the total sample population.

Socio-economic impact of HIV/AIDS and Coping Strategies of Older Persons

The results of the various in-depth interviews conducted reveal that, HIV infection within a household typically occurs to more than one family member. Often, when a man discovers that he is HIV positive, he does not take the initiative to have his wife (or wives) and children tested as well. According to health agents, when a woman discovers that she is HIV positive, the husband often refuses to be screened. Evidences have shown that the poor attitude about the existence if HIV cases within families are due to the fact that HIV/AIDS is still considered a taboo. Very often, HIV infected people strive hard to hide their serological status from members of their families. In some cases, a communication gap is purposely created.

When respondents were asked how they feel about their status when they were diagnosed with HIV and what their reaction was. One common thing among the various respondents was that, the experience was a sad one. However, people react to situation in different ways and manners. One other thing that can be deduced from the responses was that, once an individual is diagnosed with HIV/AIDS, there is the general belief that the persons had no future again and the person will never live long anymore. This reflected in the way people react to the disease when contacted it. Few of the reactions are presented below.

When respondents were asked about their reaction, one of the respondents commented thus,

"…… I was diagnosed in the year 2004, when I heard, I became afraid and I thought I would died shortly…"

Another respondent commented:

""……... I was diagnosed of HIV/AIDS about seven (7) years ago and when I heard I was so afraid but I later got over the fear quickly due to the counseling given by the Peer Educators and Doctors."

Another respondent claimed she was immediately faced stigma,

"…… immediately I was diagnosed positive, I was faced with stigma, my family rejected me and I was stopped from travelling abroad. I wanted to commit suicide by jumping into lagoon but when I was counseled I felt better now” While another respondent said “... I felt like committing suicide by jumping in to the fast moving vehicle”.

Social Impact

When respondents were asked if they have been hurt by how people or family members reacted to learning about their HIV status, there was a mixed reaction on the question. While many of the respondents said “NO” and confirmed they have been well accepted by their friends and family members. Other claimed they were discriminated and treated badly as a result of their HIV status. This can be confirmed through the comments of the various respondents. One of the respondents said

“... Iam well accepted by my family members, I eat with my sister and my husband. In fact, my younger brother encourages me a lot”

One of the respondents has a contrary experienced when she claimed she was discriminated against by her family members, neighbours and friends who knew her HIV status. According to her

“…. Yes, my neighbours and family members treated me badly when they got to know about my HIV status”.

On the question about discrimination, all the respondents claimed they were worried about the discrimination they would face with the public when they knew their status. Few of the respondents said and I quote
“... Yes, I was worried about the discrimination I will get from people, however, after receiving counseling I stopped worrying myself, after all, the sickness is not the end of road in life.” One of the respondents also said she was worried, she said “… Yes, I was worried to the extent that I could not go out of my house for a very long time, but now, I have got over the worries after receiving counseling from the Doctors and Peer Educators”

Economic Impact
The level of economic impact was examined at two levels. Effort was made to find out its impact on the sources of income and on the available disposable income of the victims and the family at large. Also, the economic impact was also examined on the cost of health care for the older persons infected or affected.

Although, respondents get their anti-retroviral drugs free from the government hospitals and establishments and also from non-governmental organization, however, the cost of other accompanies such as beverages, multivitamin supplements and nutritional diet are becoming unbearable for most of our respondents. Majority of the infected older persons are out of job due to ill-health and hence, this has further pauperized the already fainting health of the older persons. Of significant interest to mention was one of the respondents who claimed her employer terminated her appointment when they got to know about her HIV status. According to her, this was done under the pretense that she should not get involved in any strenuous activities, therefore, to have enough time to rest, they told her to stay back at home. When she was asked whether the employer compensated her in any way, she said she was given a meager of three month basic salary and that was all.

Summary
The impact of HIV/AIDS on older persons as identified by the respondents, care givers and care providers, and other category affected by HIV/AIDS were not different and were in consonance with literature. They include problems with feeding, accommodation, clothing, care and supports, the import of which cannot be over emphasized. These effects start to manifest when the livelihoods of the infected older persons are threatened through loss of work due to ill health and cost of obtaining HIV related treatment. The study revealed the deepening impact of HIV infection and diseases on the older population in Somolu Local Government Area in spite of the availability of Anti-retroviral drugs from the government Hospitals and Non-governmental actors. The social stigma experienced by older persons living with HIV/AIDS, particularly, non-immediate family members and the economic inequalities experienced through loss of income, loss or sale of productive assets as continuous living in penury combine to further deepen the impact of the disease on the bottom-line of the older persons studied. HIV and AIDS have had an effect on household incomes by reducing the available disposable income.

Conclusions
The study identified a clear impact if HIV/AIDS on older persons infected or affected with one or more adult children’s death of HIV/AIDS leaving one or two grand children to look after where poverty further magnifies the situation. Stigmatization of HIV afflicted persons, including older members, which is high and attributable to ignorance on the etiology of the disease, further compounds the problem and hinders support from the kinship system. In the event of the escalation of the problem beyond the present magnitude, the coping ability of the traditional support system is doubtful. The disease impacts on the core needs that are critical to the immediate and future development opportunities of the victims which include nutrition, care, support and accommodation. Psychosocial needs of PLWHA are identified to be critical also. The presence of HIV/AIDS in families entails various forms of instability – marital and economic – that contributes to unstable and progressively degrading living conditions for the infected older persons.

An interesting conclusion that can be gleaned from the study is that contrary to the popular notion that HIV is a death sentence because of the social stigma, the perceived incurability of the disease and the mis-information around the transmissibility of the infection from one person to another, it is evident from the findings that there has been a positive movement with time in the ability of long term infected individuals to tolerate the effects of the disease especially where their immediate communities have been empathetic and supportive. It can also be deduced that the fears that usually resides in the attitude of the wider public
with regards to HIV infection is gradually shifting to empathy in cases where there is information and where someone living with HIV is able to cope and live fairly healthier for longer periods.

At present, the magnitude of the problem as they affect older persons in Somolu Area of Lagos State seems manageable, particularly when compared with most countries having mature epidemics. However, it portends serious danger in the near future if adequate programmes and policies involving all stakeholders are not put in place to check the situation.

Recommendations
Whist we appreciates the fact that much has been documented on the scourge of HIV/AIDS in Nigeria, there is still the need to explore, document and intervene in the impact of HIV/AIDS on the older persons as a sub-group of the population in the country. The use of effective policy, legislature and action based programmes are advocated to address the issues of HIV/AIDS prevention and care, elderly supports and impact mitigation. While specific older persons focused activities are in dire need of attention, given the indirect impact of the pandemic on individual older person, household focused activities are also essential. Specifically, focused responses to older persons affected by HIV/AIDS should:

- Target the most vulnerable older persons category. Public recognition of the value, contribution and rights of older residents who are infected or affected by HIV/AIDS;
- Foster links between HIV/AIDS prevention activities, home-based care and efforts to support older persons caring for the grand children and other vulnerable groups.
- Strengthen the role of the extended family systems to support the older members of the family;
- Strengthen the economic coping capacities of families and communities through support programmes such as micro credit programme;
- Improvement on access to existing services and rights for the older persons within Somolu Local Government Area;
- Strengthen partnerships at all levels and build coalitions among key stakeholders.
- Provision of standards of care guidelines to address the specific health, economic and psycho-social needs of the older persons in Somolu Local Government Area, especially those infected or affected by HIV/AIDS.

References:
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