Socio-Economic And Socio-Cultural Predisposing Risk Factors To Hiv/Aids: Case Study Of Some Locations In Eastern Nigeria

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Citation

Abstract
The prevalence of HIV/AIDS and associated sociocultural and socioeconomic risk behaviours were studied among Commercial Sex Workers, Single parents, Long-Distance-Truck Drivers, Street Children and Students along the North-South highway in Eastern Nigeria. Screening for HIV antibodies was by EIA and ELISA. Structured questionnaires and focus group discussions were used for investigative data collection tested by t-test and Chi-square. HIV prevalence occurred as follows: Commercial Sex Workers 23%; Students 21%; Single Parents 20%, Long-Distance-Truck Drivers 19%, Street Children 16%. Major mode of HIV transmission was heterosexual transmission; severe economic repression (poverty), illiteracy, economic-driven-migrational-activities and unemployment were chief socioeconomic risk factors, while polygamy/concubinage, marriage for the dead, surrogate marriage of women to woman were main sociocultural lapses which create vulnerability of women to clandestine sex working/prostitution and subsequent exposure to STDs including HIV/AIDS. The study further observed that major high-ways constitute flashpoints through which the HIV gets foothold in the communities.

LITERATURE REVIEW
It has been recognized that HIV/AIDS is a social disease, and the outcome of social sexual behavior 1. Efforts at controlling the pandemic meaningfully and adequately need to identify and evaluate those cultural norms and practices that are likely to expose individuals to the disease. The Joint United Nations Program on HIV/AIDS 2,3, emphasized the need to address the sociocultural behaviours and values of the communities that expose individuals to HIV risk behaviours. This approach is suggested to lead to effective HIV/ AIDS intervention strategies. The developing countries particularly, sub-Saharan African bear the brunt of the HIV epidemic on account of poverty, malnutrition and virtual lack of modern health care facilities, and associated cultural, socioeconomic and political factors, which create particular vulnerability to the agonizing consequences of the infection. Recent studies show that as at 2005 about 4.5% of Nigeria’s 140 million population was infected with the virus and as many as 220,000 died from AIDS-related illnesses 4. The disease has increased the number of orphans, decreased the population of the most productive age group (15-49 years), and impacted negatively on the nation’s economy. The rate of infection varies across the country but the south-east is reported to have an average infection of 4% 5. There are, however, critical points on major high ways that constitute flashpoints and through which the diseases gets foothold on communities. This study was conducted among groups considered to be most at risk in specific locations of Enugu State Nigeria 9th-Mile-Corner in Udi Local Government Area, Eha-Alumona in Nsukka Local Government Area, Orba and Obollo-Afor in Udenu Local Government Area) remarkable for their strategic geographical locations along the north-south trucking route (the national trunk A that connects all the 17 states of the south to the north through the eastern flank). A pattern of lifestyle or culture now characterizes these trucking routes as commercial centres attracting vulnerable young ladies for petty trading and commercial sex working, important influencing factors to HIV/STD spread. It is against this background that this behavioural surveillance study (BSS) was carried out to identity most important HIV risk groups and establish socio-economic traits and risk behaviours predisposing individuals to HIV/AIDS in order to develop a suitable Community-based intervention strategy.

MATERIALS AND METHODS

ETHICAL PROCEDURES
Ethical consent was obtained from proprietors and
administrators of establishments and individuals involved in the study prior to commencement. All subjects given oral interviews were assured of protection of their privacy rights before they were given the interviews.

**Figure 1**

FOCUS GROUP DISCUSSIONS

The focus group discussions were held among the specific target groups for each location: Commercial sex-workers at Obollo-Afor, Under-privileged or Deprived children referred to as ‘Street Children’ at the 9-Mile-Corner, unwed single mothers at Eha-Alumona, University Students at Nsukka and Traders at Orba. The general topics handled included sex-related behaviours, including multiple sex-partnering, socio-cultural factors influencing the sex-related behaviours and the health implications including STD/HIV/AIDS, etc.

QUESTIONNAIRE

The same structured questionnaires were administered to participants. A test run of these questionnaires was first administered and then standardized and validated to ensure reliability of responses. The questionnaires were administered personally to those with little or no formal education but given to the literate participants for self-administration. For those guided by the interviewers, questions were posed in vernacular. A total of 5,000 copies of the structured questionnaires were distributed among the target groups during the period of study. The demographics of the respondents such as sex, age, marital status, occupation and locality, were requested and obtained. The questionnaires (both open and close-ended) were structured based on the topics previously described for the focus group discussions.

**RESULTS**

**HIV PREVALENCE**

HIV prevalence rates were observed as follows: Commercial sex workers (23%) > Students (21.%), Single parents (20%), Long Distance Truck Drivers – LDTD (19%) and Street Children (16%) (Figure 2).

**Figure 2**

FIGURE 2: HIV PREVALENCE RATES AMONG SURVEYED GROUPS

**SOCIO-CULTURAL STUDIES**

**FOCUS GROUP DISCUSSIONS**

The focus group in Eha-Alumona was made up of 25 single parents or single expectant mothers some of who confessed coming from broken homes (40%), poverty-stricken homes (24%), single parents (36%), or orphans (16%).

The level of formal education among the participants varied with their circumstances. The group in Obollo-Afor included some that were poorly educated; some that had truncated primary school education and others that were apparently secondary school dropouts. Among the 9th Mile Corner group most had no formal education. Fairly educated ones could be found amongst the Eha-Alumona group. A discussion on the means of livelihood, particularly among the Obollo-Afor, 9th-Mile-Corner and Eha-Alumona groups revealed that lack of formal education was a hindrance to seeking the sort of job that could pay enough to meet their daily needs. Hence, they either resorted to trading of sex for money or other favour.
The circumstances that exposed the group at the 9th-Mile-Corner to HIV/STD risk behaviours are worthy of note. Notable groups here are those aged 9-18 years (here referred to as Street Children) occasionally observed hawking, acting as salesgirls or boys in nearby hotels or restaurants, begging for alms mostly at late evenings and towards early mornings from long distance truck drivers/conductors and passengers during their stop over hours. They came from different geographical and/or cultural backgrounds including Enugu, Benue, Anambra, Plateau other States of Nigeria and the Niger Republic (who for some years migrated to Nigeria following famine occasioned by drought in their country). Among the Nigerians in this group, were orphans mistreated by relations they went to live with, others were offshoots of broken homes, and some have no good parenthood financially buoyant to cater for or integrate them appropriately into the society or were children of the unmarried mothers while others were physically handicapped. All had at one time or the other indulged in criminal acts ranging stealing, smoking hard drugs and in HIV/STD risk behaviours (unprotected sex or injectable drug use) as a means of earning some money for their upkeep. They were often found traveling from the very busy city life of Enugu and occasionally making brief stopover at the 9 Mile Corner en-route Obollo-Afor and finally to Benue State and beyond.

The level of awareness of HIV/STD was high as it was freely discussed among all the focus groups. Most had heard of sexually transmitted diseases such as gonorrhea and syphilis and could associate them with symptoms as painful urination, itching, ulcers, vaginal and penile discharges, etc. Some, including members of the Obollo-Afor and 9th Mile-Corner groups admitted being victims at one time or the other. Even the single mothers/pregnant ladies at Eha-Alumona indicated awareness. Once introduced in any group, the local name for STD, ‘nsi-nwanyi’ was echoed, showing they have heard about HIV/AIDS. They were, however, not too certain that they understood what it was. Some have seen victims of HIV infection (AIDS patients) and confessed that they found the sight loathsome. On discussing the cause(s), some showed understanding of its being caused by a virus that can be transmitted in the process of sexual intercourse or injection of contaminated blood and blood products or with instruments similarly contaminated. A vast majority still believed AIDS came as a result of poisoning or witchcraft. Even some of those who were convinced that AIDS is caused by a viral infection expressed the misconceptions that the virus could be spread by mosquito bites, handshakes, sharing of sleeping space, or sharing of towels, etc.

The sources of their information varied. Most heard it from the radio and television advertisements while others picked it from conversations and rumors. One thing was certain; the misconceptions came from conversational sources rather than the media advertorials. The witchcraft and poison concepts came mostly from AIDS victims who use them to explain away their predicament. Some of the factors identified during the discussions that predisposed young women to prostitution particularly included unfulfilled relationships sequel to marriage into polygamy and concubinage, woman-to-woman marriage, a situation that leads to the “married young girl being introduced to different men to bear children for the woman, the family (without children or that needs male child) or dead relation (husband, father or brother) that died without male issues.

**QUESTIONNAIRE RESPONSES**

**SEXUAL BEHAVIOURAL ATTITUDES CONSIDERED RISK FACTORS TO HIV INFECTION**

The responses of the sample individuals with various socioeconomic backgrounds are analyzed in this section. All tests of significance are conducted at critical P-value of 0.05. The analysis of responses of individuals with different educational levels shows that finance was the major motivating factor to sex. Thus it is not an exaggeration to suggest that HIV transmission is poverty-driven. There is also no statistical difference in the motivation for sex based on marital status as shown in Table 1.

**Table 1: Education and Sexual Behaviour**

On partner assessment, a high level of unfaithfulness among sex partners was reported by respondents and this was proxied by the reported frequency of partner change. A significant difference (P < 0.05) in the means was
established in the responses to frequency of partner change practiced among the surveyed groups. About 85.7% of singles, 78.6% of married, 89% of divorced, 67.3% of widows, 90.7% of widowers changed partners frequently. In general, only about 17% changed partners occasionally. On “Age of Initial Sex”, 15-20 years of age was generally indicated across the different educational levels as age of commencement of sexual contact as shown in Table 1. Age distribution also shows that younger people tend to change partners more frequently than other people.

MARITAL STATUS RESPONSES TO SEXUAL BEHAVIOURAL ATTITUDE

The analysis of the responses by the individuals of different marital status to motivation to sex showed no statistically significant difference exists between the means of the different marital status. Thus, fun and finance were indicated as motivating factors to sex by the various marital groups. Responses of different marital status to partner assessment and the means and t-test analysis indicated a significant difference between the means (P < 0.05), affirming that unfaithfulness characterized partners’ relationships in the areas. Various groups changed partners regularly.

A two tailed t-test analysis of the results of age of initial sex reported by the various levels of the marital status showed a very high statistically significant difference between the means (P < 0.05) thus indicating that 15-20 years of age is remarkable as the age of initial sexual encounter.

Figure 4
Table 2: Marital Status and Sexual Behaviour

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Motivation to Sex</th>
<th>Mean</th>
<th>p-value of diff of means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>60</td>
<td>73</td>
<td>81</td>
</tr>
<tr>
<td>Widower</td>
<td>50</td>
<td>58.5</td>
<td>0.2188</td>
</tr>
</tbody>
</table>

Table 3: Local Differences in Cultural Beliefs and Practices about Sex

<table>
<thead>
<tr>
<th>Locality</th>
<th>Local belief about Sex</th>
<th>Local view of pre-marital Woman Circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ejia-Alumena</td>
<td>Restricted for Women</td>
<td>Encouraged</td>
</tr>
<tr>
<td>Abba-Okpe</td>
<td>Not restricted for men</td>
<td>Abhorred</td>
</tr>
<tr>
<td>Ogbia</td>
<td>70</td>
<td>Yes</td>
</tr>
<tr>
<td>50</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>150</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>300</td>
<td></td>
</tr>
</tbody>
</table>

However, there is no significant difference (P>0.05) between the means, implying that circumcision is a matter of choice. On the reason for women circumcision, the means and the t-test analysis of the responses indicated that such practice is...
believed to serve the purpose of prevention of libido in the women rather than for purification and preparation for marriage. A significant difference was observed between the means (P<0.05). On the other hand, no significant difference was observed in the options for early marriage for the female child: parents’ choice, finance, maintaining relationship and avoidance of promiscuity” were not significantly different (P>0.05). However, avoidance of promiscuity had the lowest mean value (25.0), implying that parents’ choice, finance and relationship are the major reasons for giving the female child to early marriage in the various locations.

While in general, the dominant cultural practice for women who lost their husbands early in life is to re-marry, there is also the cultural practice which tends to suggest that such women could beget children for the dead husband. Such ‘free’ women become the beehive for men in the locality and thus, fueling the risk of HIV infection. Another aspect of cultural practice that tends to promote sexual promiscuity and spread of HIV is the practice that allows the unmarried women from a family without male issues to stay back in her father’s house and procreate for the purpose of getting a male successor to her family. The cultural fear is that otherwise the continuation of the household which is considered a very important cultural value would considered to come to an end. The mean number of respondents that favoured this practice is 68.5 as against 33.5 who do not approve of the practice.

**SEXUALLY TRANSMITTED DISEASES**

Awareness of STDs is considered a critical modifier of sexual behavior. Thus, it is assumed that the level of knowledge about STDs should result in greater effort to avoid these diseases. Table 4 shows that in all the communities surveyed, there is a high level of awareness of STDs. These STDs are known by different names but the common proxy for all the STDs in the communities is Gonorrhea” Table 4 shows that on average, 83% of the population is aware of STDs yet it is doubtful that this level of awareness has translated into reduced rate of infection as the demand for living today seem to cast a shadow over the uncertainty of tomorrow.

**Figure 6**

Table 4: Community Awareness of STDs

<table>
<thead>
<tr>
<th>Locality</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eha-Alumona</td>
<td>85</td>
<td>10</td>
<td>95</td>
<td>89.5%</td>
</tr>
<tr>
<td>Orba</td>
<td>70</td>
<td>20</td>
<td>90</td>
<td>77.8%</td>
</tr>
<tr>
<td>Nsukka</td>
<td>78</td>
<td>12</td>
<td>90</td>
<td>86.7%</td>
</tr>
<tr>
<td>Obollo-Afor</td>
<td>60</td>
<td>30</td>
<td>90</td>
<td>66.7%</td>
</tr>
<tr>
<td>9th Mile</td>
<td>73</td>
<td>10</td>
<td>83</td>
<td>88.2%</td>
</tr>
<tr>
<td>Enugu</td>
<td>86</td>
<td>5</td>
<td>91</td>
<td>94.5%</td>
</tr>
<tr>
<td>Total</td>
<td>454</td>
<td>87</td>
<td>541</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

The attitude of the community towards those infected with STDs may be important in determining the level of efforts people make to avoid these diseases. If the community is sympathetic towards people with STDs, it may not necessarily discourage people from sexual behavior that lead to contamination with these diseases but may imply that such would take extra measures to hide their infection. The general attitude among the surveyed population is that of stigmatization leading to shame as this is regarded as a sign of promiscuousness on the part of the sufferer. Yet the incidence of STDs among the target population was very high as many experienced symptoms of STDs or had previous exposure to STDs. The percentage of the target population who experienced symptoms of STDs varied between communities: Eha-Alumona (68.4%), Orba (61.2%), Nsukka (71.4%), Obollo-Afor (57.9%), 9th Mile (87.5%) and Enugu (54.5%). Known symptoms, such as pain and ulcer were common among the respondents. However, pain was the major symptom associated with the sufferers. Among those who indicated having been diagnosed of STD, 75% of the diagnoses was conducted by medical laboratories while 25% was diagnosed by examination by physicians. It is likely that many more suffer the symptoms but never tested for it.

There is high preference for traditional herbal cure or self medication among those who suffer STDs in the communities. Over 86% of all those who experienced STD preferred either of these means of treatment to western orthodox medicine. The main reasons given for this preference is lack of finance to afford conventional medicine (66%) and to avoid social stigma associated with exposure to conventional treatment (34%) since traditional healers are more secretive in their dealings with their patients and are therefore, less likely to expose their patients. It is generally believed that traditional cure is less expensive than orthodox medicine, hence, the preference for traditional medicine is more likely to be associated with the prevailing poverty in the communities rather than social stigma, though the latter is also reckoned with in the decision where to seek cure.
ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

A major predisposing factor for HIV/AIDS is lack of awareness or denial of the existence of the disease. This study sought to find out the level of awareness of the target population about the HIV/AIDS. Among the target population and in all the communities surveyed, there is a high level of awareness of the reality of HIV/AIDS. Virtually all the respondents (with the exception of only three respondents) acknowledged the existence of the epidemic. The problem, however, is that most of the respondents provided superstitious explanations for the spread of the disease. For example, about 32% of the respondents suggested that HIV/AIDS was God’s scourge for moral failure; about 31% associated it with witchcraft, while about 38% associated with poison. The problem is that these superstitious explanations may divert attention from the real causes of HIV and thus lead to inappropriate remedies and behavior modifications.

Figure 7

Table 5: Sources information and perceived Mode of Contacting HIV

The result of the responses in Table 5 show that the electronic medium “Radio/TV” is generally the most common source of information about HIV in the communities surveyed. Many also come to know about HIV/AIDS through conversation with other persons and infected individuals. Table 5 also indicates that the respondents’ opinion on perceived modes of contracting AIDS were sex and blood transfusion as shown by the percentage of positive responses in the Sex/Blood column. The symptoms that characterize HIV were identified as “Loss of Weight” (48%), “Chronic Cough” (31%) and Diarrhoea (20%). Community attitude to infected people varied as well but the general attitude was stigmatization (41%) withdrawal from the infected person (46%) and only 11% of the respondents indicated that community attitude to infect persons was sympathy.

In all the communities, the riskiest groups were identified as commercial sex workers (61%) and students (39%) while the main predisposing factors were identified to be poverty (79%) and greed (29%). Obviously, policies aimed at fighting the HIV/AIDS scourge must be directly targeted at these two main groups. Reducing poverty among the groups will also help to reduce the level of susceptibility to the disease. Opinions of respondents suggest that the most difficult problems faced by infected persons is rejection by society and poverty.

BEHAVIOUR CHANGE OPTIONS

The results of the study shows that most respondents clearly recognized that HIV is most commonly transmitted through sexual activities, but surprisingly most of the respondents considered abstinence as “unhealthy” and “impossible”. Significant number of respondents indicated that they have never really tried abstinence. Reasons given for not trying include habit and fear of losing friends. Yet, in spite of their inability to abstain, respondents acknowledged the potential values or benefits of abstinence.

Among the target group, fidelity is generally viewed as “impossible”. This is probably because fidelity is inconsistent with the very motive of the sex-for-payment trade. Nevertheless, the respondents recognized the dangers associated with infidelity which were acknowledged to include broken homes, unwanted pregnancies and probability of contracting any of the STDs including HIV. Most however, believed that instead of fidelity, use of condom should be encouraged. Even then, attitude to use of condom varied as some feared it might break in the process and some other thought it was interference in the enjoyment of the sexual act. It is instructive that not even religious believes hindered the respondents from the use of condoms as they used such phrases as “personnel affair, not church business” and “protection against AIDS before church” to describe their practical decisions to use condoms. Even among teenagers, the use of condom is very rampant in the surveyed communities, though some feared that such widespread use of condom could predispose young people to promiscuity. And on the reason for increased incidence of AIDS inspite of condom, this was attributed to improper use of condom.

DISCUSSION

This laboratory based epidemiologic study was carried out to establish the prevalence of HIV among target population
while the behavioral surveillance studies (BSS) served to assess the socio-cultural and economic factors in the areas that expose people to risk behaviours predisposing to HIV/STDs. The socio-cultural factors were analyzed in terms of age, sex, occupation, and location of subjects. The BSS, therefore, attempted to address or provide the missing information in the present effort against the spread of HIV/AIDS in Nigeria, including the level of awareness of high risk groups and risk behaviours, socio-cultural beliefs and practices that are possible risk factors in HIV infection, factors predisposing women (in particular) to prostitution.

Results of the laboratory screening for HIV indicated high prevalence rates of HIV among the established commercial sex workers as well as others with lifestyles predisposing to HIV infection: Commercial workers 23%, students 21%, Single parents, 20%, Long distance truck drivers 19%, Street Children 16%. However, there was no significant statistical difference in the observe prevalence ratios (p, 0.05) This paradigm of the increase has serious implications for the country, and as observed in the sociocultural reports of this study, the generalized concept that commercial sex working is the major risk factor to HIV infection in the country according to earlier reports 6,7, is herein broadened, the term has, due to serious sociocultural factors and socioeconomic recession included all those who engage in clandestine sex working particularly, students, single ladies, people who must live far away from their marital homes on business trips such as the long distance drivers and their associates, underprivileged and deprived children and all those who have no appreciable means of livelihood who are forced to supplement their income by sex working which has essentially become an economic driven job in the country. Further implication is that anyone who engages in multiple sex partnering is at high risk of HIV infection.

HIV spread in Nigeria is primarily a heterosexual phenomenon (multiple sex partnering): a function of sociocultural and economic predisposition: each filters out and merges into the final outcome: HIV/AIDS (Figure 3). However, there is no strict age or class divide or bias, as young and old are involved in commercial or clandestine sex working (though not resident in hotels), while the ultimate perpetrators are the rich or apparently rich financiers or customers.

HIV is a sociocultural and socioeconomic disease in Nigeria, and the paradigm of its infection and spread particularly within the local communities is a reflection of the sociocultural and socioeconomic profile of the people. The factors have overlapping or interconnected relationships – none excludes the other in importance or in enhancing HIV spread and progression. These factors are further explained in the preceding discusses on the sociocultural studies. However, the paradigm is illustrated below (Figure 4)
observed among sampled population (>85%). This awareness did not, however, always lead to accurate understanding of the disease because the results of the study further showed that there were erroneous perceptions about HIV/AIDS, in particular; the true position being overshadowed by superstition. Varying opinions about the precise aetiology of AIDS and modes of transmission of HIV were expressed. Whereas majority correctly pointed to a virus, HIV as the causative agent of AIDS and heterosexual intercourse as a major vehicle of HIV transmission, others erroneously insisted that AIDS was caused by witchcraft, poison from enemies, punishment from God, some sort of ill luck, etc. These misconceptions correlated partly with the level of illiteracy observed in the population and partly with the prevalent (spiritual) belief system. The primordial belief system in African and especially among the Igbo is that “nothing happens by chance”; someone or some mystic dark powers are held responsible for every unfavourable occurrence or misfortune including HIV/AIDS and death. This system of belief has no ethnic, age, occupation, educational levels or sex bias.

There is a high level of awareness of risk factors and high-risk groups among the sampled population. About 90% of participants in the BSS referred to AIDS as disease of prostitutes and promiscuous people. Prostitution (multiple sex partnering and sex working) was regarded by more than 80% of participants as major predisposing risk behaviour in the area. On the other hand, poverty (hardship) and greed were alleged by 80% of them to be the factors predisposing to prostitution. Rapid spread of HIV infection in the area was overwhelmingly attributed to poverty, which compelled vulnerable young women of childbearing age to indulge in unprotected sex and hence the HIV infection. This observation was confirmed by the findings8 who studied the hazards of prostitution. Similar reports6,9, also indicated the impact of prostitution on HIV transmission among Africans. From the BSS, it is apparent that poverty, unemployment and illiteracy were factors influencing the choice of most young women to prostitute. It was pointed out that a common feature of the HIV epidemics is the rapidity of the spread, once the virus finds a foothold in a vulnerable population10. Other researchers7,11 reported steep increases in the rates of prostitution arising from illiteracy, poverty and freedom of sexual expression as was also observed in this study. Thus, these are major factors responsible for the introduction and dissemination of HIV/AIDS into Nigerian homes that ought to be addressed in any meaningful HIV/AIDS intervention programmes.

The population became aware of HIV/AIDS either from the mass media (particularly radio and television) or as usual, rumours and peer group conversations. The presence, in the communities, of known cases of those infected with HIV/AIDS was source of information with gossips aiding in the dissemination. That none of the respondents or discussants in the BSS indicated knowledge of any HIV/AIDS victim that had been cured underscored their concept of incurability of the disease. Despite the apparent incurability of the disease, for about 70% of the single women getting pregnant was still the major concern in unprotected sex rather than HIV infection. In fact, this attitude of “one must die of something someday” is reminiscent of one caught between “the devil and the blue sea”, death by hunger and death by HIV/AIDS. It further shows the societal concern regarding extramarital pregnancy – the stigma of getting an illegitimate child is paramount to the concern of contracting an infectious disease.

Data from the oral discussion and questionnaire responses revealed a wide range of beliefs and practices predominant in the area, which influence their sexual behaviour. Heterosexual contact was observed to be the major sexual attitude in the areas as also reported 12. The cultural beliefs and customs that apparently enhanced risk behaviours include polygamy/concubinage, marriage for the dead, surrogate marriage of woman to woman, procreating for late husband and retaining female children to procreate for the families in need of male children. These practices have their foundation from the philosophy of the Igbo ethnic nationality that it is a calamity to end a family’s genealogy through lack of male off-spring. This philosophy, places a high premium on getting male children at all costs even if it means a female child staying back, rather than marry out, to beget a male child who will continue the family lineage, care for the parents at old age and accord them befitting burial when they die. While such practices are now receding due to the influence of Christianity, the vestiges of the practice seem still to exert a lot of influence in the actual lives of communities particularly in the less developed rural areas. This desire for male child to continue the family lineage explains the social pressure experienced by childless couples or those with only female children to enter a second or even third marriage or the indicated practice of marrying for a late husband especially the one who died without a male child.

The implication of all these is that extramarital sexual
relationships, in most cases with more than one partner, are contracted.

On the other hand, many marriages are contracted for favors or to keep relationships, and majority of the girls given into such marriages face the dilemma of incompatibility. Consequently, most run out on the unwanted husbands and go into prostitution; or in the case of being betrothed to very old men, the latter dies shortly and the widowed young person goes into sex for favour or money. This observation was confirmed by the reports12, on his epidemiological surveillance of this area. At another extreme, unmarried or single women rear children outside marriage with as many men as possible fathering their children. Therefore, the issue of sticking to one partner remains difficult in the given situation of poverty and cultural practices that seem to make fidelity difficult. The summary impact of these cultural beliefs and practices is that they fuel infidelity, and/or high frequency of partner change or multiple sex partnering. This phenomenon was thus reported by more than 80% of respondents or discussants to be the major cause of the increased level of HIV transmission among couples. This is consistent with the reports13 on the danger of increased HIV transmission between couples with multiple sex partners.

Multiple sex partnering (in its various forms) was identified as the important socio-cultural factor in this study, which predisposes people to HIV/AIDS. Earlier reports 6,12, showed a high level of commercial sex working (a known high level of multiple sex partnering) in Nigeria. Others 14,15, also indicated that sex working and/or multiple sex partnering constitute risk factors for HIV transmission in both urban and rural areas. Although viewed quite apart from commercial sex working, these traditional sexual behaviours (marriage for the dead, concubinage, woman-to- woman marriage, pre- and extramarital sex) promote the same practice and HIV/AIDS risk behaviours as prostitution or sex working, namely multiple sex partnering.

Heterosexual rather than homosexual behaviour predominates in the areas of study. Few instances of homosexualism and lesbianism were observed among the children in the 9th Mile Corner and some young people encountered during the study. Nevertheless, sexual activity (pre-marital sex) was observed to precede marriage for more than two years on average in these areas, and more than 40 percent of all currently married women were in polygamous marriage or in extra-marital contacts prior to marriage. This situation enhances disintegration and/or incompatibility in marriage, which accounts for selling of sex or prostitution and consequently HIV transmission among women. Results of this study confirms earlier reports16 on the risk associated with heterosexual behaviour. Some of the observed culturally allowed heterosexual behaviours which could constitute risk of HIV infection include freedom of sex for men once of age, regarded not as promiscuity but as sign of masculinity, maturity and growth.

Socioeconomic factors indirectly influence HIV/AIDS transmission since they influence the individual’s decision to indulge in HIV/AIDS risk behaviours. Poverty was considered a major factor influencing indulgence in heterosexual activities, an established sociocultural and sexual behavioural HIV-risk factor, in these areas. This is supported by17, who iterated that poverty makes people tend to be less anxious about risk-taking particularly for a long-incubating and slow-killer diseases like AIDS. Women in Africa were shown as the principal disseminators of HIV/AIDS in the current epidemic as a result of their lower socio-economic status13; and according to18, socioeconomic impact of AIDS hinges on household resources and beyond. Reporting on HIV/AIDS and urban poverty in South Africa, it was concluded that the burden of HIV infection cuts across nations, but lies more heavily on poorer nations and peoples15.

The age group, 16-30 years (considered the age of high youthful exuberance) represents the group of highest HIV prevalence as well as the highest sexual activity, hence highest risk group in the area. There is presently a reduction in the age of menarche; about 85% of the respondents reported that sexual experimentations begin early (10-12 years) and by the age of 15-16, individuals have exchanged partners very frequently. This may, perhaps, explain why multiple-partner sex is regarded as normal or at least, commonplace. The observed frequency of teenage pregnancy was earlier reported6 thus confirming sexual networking among adolescents. To address the prevailing trend in teenage pregnancy and its consequences, namely HIV infection and maternal death, the United States Public Health Service19 gave recommendations for HIV counseling and voluntary testing for pregnant women especially teenage mothers.

In terms of sexual behavioral attitude, the age bracket 16-30 was identified (from questionnaire responses of this study), as the age in which initial sexual contact commences and frequency of partner change is at its peak as earlier
indicated. The former Nigerian Minister of Health, in his opening address to the World AIDS Day (WAD) Campaign in Nigeria observed similar trend in HIV prevalence among individuals aged 15-49 years, who he considered risk groups in HIV transmission. Premarital sex and/or promiscuity as observed from the study were, therefore, the hallmark of this age group; and the greatest motivating factor was financial reward. The observed high level of promiscuity among the youth could be attributed to peer influences and the associated identity crisis. This view is supported by the study on adolescents’ sexual behaviour in Calabar, Nigeria. Predominance of promiscuity was also reported by CDC21 found on their update on mortality due to HIV infection among persons aged between 24 and 44 years in the United States. By this report, it is thus affirmed that the problem of young people and HIV transmission is worldwide.

The female sex was observed to be more vulnerable to unprotected sexual exposure and hence to HIV infection basically because their circumstances within the prevailing culture constrain them to opt for sex for economic reasons or for the gratification of other material needs and protection. The males were, on the other hand, reported to be motivated by fun. The reported vulnerability of the females to sex could, therefore, be assumed to account for the increased level of STDs including HIV transmission among them. The observations in the study area were that many women, especially those of child-bearing age in these areas live below subsistence level, hence the reliance on other quick or immediate sources of money for personal, family and social support. In addition to their socio-economic and cultural vulnerability, many women are married to or are sexual partners of men who also have sexual contact with prostitutes. On the other hand, the men generally become sexually active several years before marriage, during which period they have had ‘free women’ (often single mothers, and sometimes prostitutes with multiple sex partners) as their sexual partners, and through these ‘free women’ STDs, including HIV/AIDS are contracted and subsequently transferred to their wives. This phenomenon was earlier reported in the work carried out on the sexual activities of men and their associated risk factors. The problems of transmission of STDs and related infections identified in these areas were similarly observed in earlier reports on the current and future dimensions of the problems associated with STD transmission in the third world.

On behaviour change options, condom use was indicated by more than 90% of subjects especially those aged 16-30 years as their choice option. Abstinence and fidelity, though viewed positively as the best safeguard by more than 90% of subjects, were considered impracticable hence the option for condom use. The pattern of sexual behaviour, particularly high level of promiscuity and/or multiple sex partnering, observed in these areas during the course of this study has serious implications for HIV control. This is because successful behaviour change requires strong belief in one’s capabilities to exercise personal control over one’s emotions. Self-directed change (if and when people understand how personal habits threaten their well-being) is assumed to be the basis for effective HIV preventive strategies. The results of this study nevertheless disclosed the inability of respondents to practice self-directed change and/or positive behaviour change options in form of abstinence and fidelity to partners allegedly on account of poverty, habit, fear of losing friends, or inability to exercise some level of control over sexual passion. This need for positive behaviour change option was indicated by AIDS Control and Prevention3 to be the basic and worthwhile HIV/AIDS control measure. The US Department of Health and Human Services, on the other hand reiterated the need for behaviour change option as the basis for HIV control and Prevention in this Third Decade of HIV emergence.

Majority of the participants would wish to re-infect others or to commit suicide. These feelings are mainly due to the stigma associated with the disease as the infected are seriously rejected and discriminated against in most spheres of life. This ugly trend could be circumvented by enactment and enforcement of appropriate laws to accept, accommodate and help the people living with HIV/AIDS (PLWHA) in order to reduce their emotional difficulties as well as engender openness in them (to prevent further spread or re-infection). In addition, using them as models in the intervention programmes could lessen their rejection.

CONCLUSION

This study set out to investigate the prevalence of HIV among individuals with high risk lifestyles and the associated socioeconomic and cultural practices that predispose to the spread of HIV in certain locations in Nigeria. It emerges that poverty and the quest for survival provide the base of behavior that tend to enhance the spread of this disease particularly among vulnerable groups including young ladies, individuals from broken homes, migrants, unemployed, deprived or Street children etc.
Increased rate of HIV infection has therefore been inextricably linked to socioeconomic factors (mainly poverty) that place women at disadvantaged position. Alleviation of poverty and women emancipation programs may contribute positively towards effective HIV control and/or prevention.

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