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Ethno Med, 5(2): 141-147 (2011)
PRINT: ISSN 0972-0073 ONLINE: 2456-6802

Socio-cultural Factors Responsible for Increasing Rate of HIV/AIDS in Akwa Ibom State of Nigeria

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KEYWORDS Sero-Prevalence. Colony. Abrasions. Vulnerability. Negotiate. Pandemic. Transmission. Promiscuous

ABSTRACT Akwa Ibom State is rated second in terms of HIV/AIDS pandemic (with 8.1 seroprevalence rate) out of the 36 states in Nigeria[1]. The authors carried out an intensive three month fieldwork in Uyo capital area and its surrounding villages of Itam, Itiam and Mbiabong Anyaya, using purposive and random sampling techniques. The findings show that the people's belief system and socio-cultural practices favour the contracting and spread of HIV/AIDS. The researchers' recommendations for mitigating the spread of the pandemic include massive awareness campaign about covert cultural practices that aid the spread, and opening up of more Voluntary and Counselling Testing Centers (VCCT).

INTRODUCTION

Nigeria is a very prominent country in the African continent. It is believed, based on the country's population of 140 million (2006 NPC), that for every five Africans, one is a Nigerian. By the year 2005, the sub-Saharan Africa where Nigeria rightly belongs, had about 25.8 million people living with HIV/AIDS. In 2005 alone, there were about 3.2 million newly infected AIDS cases with seven point two percent seroprevalence rate; and 2.4 million deaths (Lamptey et al. 2006).

According to the 2003 HIV/Syphilis sero-prevalence sentinel survey, the Nigerian national average was 5.0%. This placed Nigeria as the third most affected nation in the world (Inyang 2005). But currently, Nigeria ranks 4th in the world with a prevalence rate of 4.4%. Akwa Ibom State is one of the 36 states in Nigeria, and is located in the south-eastern part of the country and precisely in the south-south geo-political region. It has a population of 3.91 million people (Census 2006) spread across 31 local government areas. The state occupies a landmass of 8,412 square kilometers (Okon 2006). Its capital is Uyo metropolis, and its ethnic groups are Ibibio, Annang, Oron, Eket, Ibeno and Mbo.

The Problem

The first case of HIV/AIDS infection in Akwa Ibom State was reported in 1989. All the three Federal Ministry of Health HIV/Syphilis sentinel sero-prevalence studies conducted so far in 1999, 2001 and 2003 in succession have placed Akwa Ibom State among the first five HIV/AIDS most affected states in Nigeria. Since HIV/AIDS status test is voluntary (VCCT), it is increasingly difficult to know the rate of infection among men and women in the state.

However, estimates using the 2003 HIV/Syphilis sero-prevalence sentinel survey among women attending antenatal clinics indicate that between 200,000 and 250,000 Akwa Ibom State women aged 15 – 49 years may be living with the virus. The Federal Ministry of Health (FMOH) sero-prevalence study of 2003 put Akwa Ibom State at 7.2% prevalence rate. Looking for reasons why women may be more affected than men, Akpabio (2005) said, biologically the vagina has a large surface area, so sperms stay longer in it. Women also easily sustain abrasions during sexual intercourse. The immature genital tract of a girl's grub is likely to tear during sexual activity thus creating a higher risk of HIV transmission during unprotected sex. Culturally, women are not expected to negotiate safe sex with their partners even in a polygynous relation, so they lack control in sexual decisions. Besides, many women are very poor for various reasons so their economic dependence on men causes them to exchange sex for money. If HIV/AIDS is found among many women, the men who have sexual intercourse with them cannot be all free from the pandemic.

Review of Relevant Literature

In the words of Inyang and Ituen (2000), low level of literacy has been discovered as one of

the reasons for vulnerability of people to most contagious diseases in Africa. Lamptey et al. (2006) particularly held illiteracy as a principal factor fuelling the spread of HIV/AIDS in many parts of sub-Saharan Africa.

World Bank (1991) further argued that the low level of education forces the majority of the sub-Saharan African urban poor to be engaged in low-income jobs which cannot guarantee protection from poor negative health outcomes. Nyanguru (1999) argued vehemently that poverty opens up families to different types of abuses especially child abuse that could be sexual or emotional. Such abuses most often lead to the spread of HIV/AIDS pandemic. Apart from the level of poverty thesis; social interactions among kinsmen and lineage members based on cultural principles such as solidarity of the sibling or lineage groups have been detected as some of the major causes of the spread of contagious diseases like tuberculosis, leprosy, and HIV/AIDS. For example, Kapungwe (2002) discovered that traditional sexual socialization process such as in puberty rites was as facilitator of HIV/AIDS among the adolescent girls in Zambia. Ochieng – Odhiambo (2002) said that traditional rites such as in the institution of 'Widow' Guardianship among the Luo as one of the main factors in the rapid spread of HIV/AIDS among the Luo of Kenya.

World Bank (1992) said it has embarked on rural development projects that are capable of making some rural communities turn away from their elaborate socio-cultural rites and channel such energies into socio-cultural developments for the alleviation of poverty. Such projects include the China Gansu Province Development Project, with agricultural component that aims to increase agricultural productivity and incomes in one of China's poorer region. Another example is that of Women in Development Project in Gambia aimed at making women's skill more marketable by promoting basic literacy and training activities and strengthening of women's groups.

It is believed that when local communities are empowered through projects that are meant to alleviate poverty; practices that hitherto worried the poor such as widow inheritance, levirate, cohabitation, women trafficking and their rituals capable of leading to the transmission of diseases, would reduce drastically.

Theoretical Framework

The Colony Approach

The Colony Approach (Modo 2007) and Health Belief Model (Rosenstock 1974) are used here, as point of departure for this paper. The colony approach visualizes HIV/AIDS as a pandemic that has become entrenched in a given environment referred to as colony in Nigeria. Those not infected are affected and include some workers in the colony, relatives of the infected, living within the colony, visitors and others who visit the infected. In such a colony care must be taken to avoid fresh cases of infection. So, all former socio-cultural systems of relating with one another in the community should be modified in order to check incidences of new cases of infection. The efforts of the World Bank in funding HIV/AIDS research and treatment in Nigeria and the cooperation it receives from the Nigerian government are seen as aspects of the relationships within the colony.

Health Belief Model

It is also observed that all human societies have different ways of classifying disease or ill health. This is usually in line with their health belief system. The health belief model (HBM) suggests that the beliefs and attitudes of people are crucial determinants of what they call disease and the health related actions they take to combat such diseases (Jegede 1998).

Rosenstock (1974) observed that people's ability to utilize health measures is based on four variables. They are (i) the person's view of his own vulnerability to illness (ii) The belief about the severity of the illness (iii) the person's perception of the benefits associated with actions to reduce the level of severity and (iv) his evaluation of potential barriers associated with the proposed actions. Rosenstock (1974) was of the opinion that these were actually the determinants of a person's perception of his health condition and the actions he was likely to take to move from ill-health to health. This leads to health seeking behavior and decision making process. For an individual to constantly remain healthy he must continually take positive decisions and dutifully act upon them. Rosenstock (1974) further noted that a person's susceptibility to disease can be at three levels: that of high level if

there is real danger of contracting the disease, medium level, where there is a probability that the person may contract the disease and low level when there is assurance that he can never contract the disease. It is therefore obvious that the action that an individual will take when faced with a health problem depends on the perceived effects and consequences of such diseases. The ability of an individual to take action to ward off a disease further depends on other factors such as age, sex, marital status, income, education, place of residence and even insurance scheme.

In health belief model there must be a focus and limit to what to believe and the action to be taken should be specific. A close look at HIV/AIDS shows that there is high susceptibility among the people in Akwa Ibom State of Nigeria. The colony approach and health belief model will both serve as point of departure for this research on HIV/AIDS among women in Akwa Ibom State of Nigeria.

The Objectives

The general objective of this paper is to explore the socio-cultural factors that lead to increasing HIV/AIDS infection among the people of Akwa Ibom State of Nigeria.

Specifically, the study intends to:

a) Find out the ways women in Akwa Ibom State easily contract HIV/AIDS
b) Find out the part men play in this increasing women's vulnerability.
c) Recommend ways of reducing the spread of this scourge in the state.

METHODOLOGY

This research was carried out in a period of three months, September – November 2006, by the researchers ably assisted by 8 research assistants (six ladies and two men) who were all undergraduates of the University of Uyo in Akwa Ibom State capital. The work was carried out within the Uyo axis including the Uyo metropolis: Itam, Itiam and Mbiabong Anyanya. It is a descriptive survey using purposive sampling techniques targeting women from 15 years upward and men 18 years and above. In the three villages, attempts were made to visit every house using the census method but in any house where a woman was interviewed the man was left out.

Where no adult man or woman was spotted, the house was excluded. The research assistants moved in pairs of two ladies each (three pairs) to the different houses, while the two men went together. Men interviewed the men folk alone while women interviewed the female folk only in order to maintain cultural tradition in matters relating to sex,

At Uyo metropolis, the four heavily populated residential areas were chosen for the research. They are Ibom Plaza to Oron Road, Ibom Plaze to Ikot Ekpene Road, Ibom Plaza to Aka Road and Ibom Plaza to Abak Road. For a better coverage of the area, every fourth house was visited beginning with the fourth house nearest to the Ibom Plaza. All the interviews were conducted in the evening between 4pm to 7pm. In all 197 respondents were interviewed, including 64 men and 133 women.

Research Questions

The research attempted to answer the following questions:

a) Is the spreading of HIV/AIDS among women facilitated by promiscuous nature of the women?
b) Is the scourge among women affected by the observed abject poverty among the women folk?
c) Are there socio-cultural factors that aid the spread of HIV/AIDS among men and women in the state?

RESULTS AND DISCUSSION

From the data gathered on the ages of respondents, 78% of the female respondents were below 45 years old. 85% of the men were aged below 45 years. This means that the most sexually active members of the community are the bulk of the respondents.

Within three months of this fieldwork, 133 women were interviewed while 64 males were interviewed. In addition to the fact that there were more female research assistants, there were more female than male respondents because women were mostly found at home during such evening interviews. About 11% of the female respondents did not go to school at all. 33% of the women stopped at primary school thus making over 40% of women respondents in the research; people at the low rung of the societal ladder.

Although less than 5% of male respondents did not go to school at all, 46.8% did not go

Table 1: Demographic factors

Variables	*Women*	*%*	*Men*	*%*
Age-range				
15 – 24	25	18.7	12	18.7
25 – 34	53	39.8	25	39%
35 – 44	27	20.3	18	28
45 – 54	21	5.7	7	10.9
55 and above	7	5.2	2	3.2
Total	133	100	64	100
Sex				
Uyo	50	25.3	20	10.1
Itam	26	13.2	12	6.0
Mbiabong Anyanya	28	14.0	14	7.1
Itiam	29	14.7	18	9.1
Total	133	67.5	64	32.4
Academic Qualification				
No education	15	11.2	3	4.6
Primary school	44	33	27	42.2
Secondary school	54	41	17	26.5
Diploma, NCE	13	9.7	5	7.8
Degree	7	5.2	9	14.1
Higher degree	0	0	3	4.6
Total	133	100	64	100
Marital Status of Respondents				
Single	24	18.1	10	15.6
Married	78	58.6	48	75
Single parent	4	30	1	1.5
Divorced	11	8.2	4	6.2
Separated	7	5.2	1	1.5
Widowed	09	6.7		
Total	133	100	64	100
Occupation of the Respondents				
Farming	19	14.2	5	7.8
Petty trading	70	52.6	12	18.7
Business	13	9.7	20	31.2
Other professional	-	-	4	6.3
Public/civil servants	10	7.5	18	28.2
Total	133	100	64	100
Religious Affiliations of Respondents				
Christians		161	81.7%	
Moslems		-	-	
Traditional		36	18.2%	

Source: Field work 2006.

beyond the primary school level. But unlike the female with 5.2% as graduates, 18.7% of the respondents held degrees and postgraduate qualifications.

On religious affiliation, everybody claimed to be a Christian but some were able to distinguish themselves from others by leaning more on traditional religious system. 18.2% of the respondents adhere to traditional religion while 81.7% are Christians. 24 (18.1%) of the females were not married while 22 females (16.5%) had quit marriage or become disenchanted with it. Ten (10) men (15.6%) had not married at all, while only 6 (9.3%) had quit marriage. It is obvious that more women than men had quit marriage because of one frustration or the other. Many women (18%) were not married for various reasons including being disappointed or jilted by men at various times.

About 14.2% of the female respondents had farmlands at the outskirts of these villages, while only 7.8% of the males had such farms. While majority of the women (52.6%) saw themselves as petty traders; only 7.8% of the males claimed to be farmers. Men were higher than women on the professional and teaching sectors. While 20% of the men talked of business, only 13 (9.7%) of the women talked of being businesswomen (Table 1).

Substantive or Core Issues

The first of the structured interview questions was on the knowledge of the existence of HIV/AIDS, the mode of its transmission and its known causes. The second set was on socio-cultural influences, which were based on cultural practices (Table 2).

Table 2: Respondents knowledge of the existence of HIV/AIDS

Knowledge of HIV/AIDS	*Yes*	*%*	*No*	*%*	*Total*
Men	60	30.4	4	2.1	64
Women	120	60.9	13	6.5	133
Total	180	91.3	17	8.6	19(100)

Majority of the respondents (91.3%) knew of the existence of HIV/AIDS. Indeed the local name they called it within the communities is Udono Itia-ita, meaning figure eight. The name conveys the image of a bent HIV/AIDS patient who looks like figure 8, others call AIDS as eight.

Table 3: Respondents knowledge of the mode of transmission

Knowledge of its mode of transmission	*Yes*	*%*	*No*	*%*
Men	10	5.1	54	27.4
Women	33	16.7	100	50.7
Total	43	21.8	154	78.1

Source: Field work 2006

The respondents in the four communities did not have the basic knowledge of modes of transmission of HIV/AIDs. They all knew that HIV/AIDS can be contracted through sex with an infected person but only 21.8% of all the respondents knew of other means such as

infected pregnant mother to child transmission; transfusion of infected blood, and incision with HIV infected sharp object. Indeed they have their other strong beliefs about the causes of HIV/AIDS (Table 3).

It is the general belief of the people that the death of any person is caused by enemies no matter how old the person is. Some enemies give poisonous substances to unsuspecting people and this is different from the activities of witches. Some see HIV/AIDS as nature's punishment for sinful life (Table 4). Others see it as mysterious and unexplainable. Some simply say that they do not know the cause and will not want to guess or believe what others say. Those who were pressed further to talk among those who do not know the cause, suspected use of same toilet, shaking of hands, sleeping on the same bed, eating together, saliva contact and wearing of same clothes, with the infected. The interviewers corrected them and also discussed with them of certain basic facts every one should know about HIV/AIDS.

Table 4: Respondents belief about other causes of HIV/AIDS

Causes of HIV/AIDS	*No. respondents*	*%*
Nature's punishment for infidelity	30	15.2
Witchcraft	39	19.7
Sickness from enemies	25	12.6
Mysterious	45	22.8
Do not know	58	29.4
Total	195	100

Source: Field work 2006

The different opinions of the respondents are all very useful. The erroneous suspected causes of HIV/AIDS are really the causes of the high level of stigma associated with the disease.

HIV/AIDS Transmission through Multiple Sex Partners

It is agreed by respondents that HIV/AIDS exists and this was associated with multiple sex partners. In the communities, women do not have the right to refuse sexual request from husbands. Some married men also see it as a virtue to have female friends, some of whom are well known to their wives. A wife that suggests condom to a husband according to a female respondent at Uyo, is promiscuous and could be ostracized for that. Some girls also insist that the boyfriends should not talk about condom for sex unless the trust is not there. Men by tradition are not sick, and since testing is voluntary (VCT), only women HIV statuses are known and mainly during antenatal examinations.

Socio-cultural Practices and HIV/AIDS

Another very important question in this research is whether there are socio-cultural factors that could be responsible for HIV/AIDS among the people. Most socio-cultural factors appear conjectural in nature but because of their association with blood and blood fluids, their probability as causes of HIV/AIDS is high. Some of our discoveries account for what respondents see as mysterious in Table 4. Some of these unmarried girls have been known to have entered into blood covenant or oath with some boys in order to ensure they are eventually married. Nobody admitted such covenant among our respondents but such a disease could be transmitted through such process. One of our respondents knows of at least one victim of the covenant.

Out of poverty or cultural inertia, many family members make use of one or two toothbrushes every morning and evening. It is believed that mere cleaning with water is enough before another member of the family uses it. This is a probable way of contracting HIV/AIDS from bleeding gums.

Recently, one female respondent confided in one of our field assistants that she does not like men. She hates men so she makes up by kissing and fingering the vagina of female friends of same interest, yet she is married. She could be called a lesbian. We believe the risk of contracting HIV/AIDS is very high if a girl with a wound in the finger uses that finger to penetrate the vagina and to turn round the vaginal fluid of an infected girl for pleasure. Some village men take pleasure in doing this to some loose girls too.

Some people are too particular about their faces and that of their friends. People most of the times have little cuts in the fingers as a result of accidents with knives during activities like cooking. They very often use the same finger to press ripe pimples on the faces of their friends. They press out the pimple and the blood often smears on their fingers and wound. An infected blood can cause trouble for the other person.

It is also believed that the sharp knife women

and girls use to cut some delicacies such as Ukwoho and Edikan Ikong or the knife for removing coconut from the shell can give a cut to different people's fingers as they are used in common. These are possible ways people get to contract HIV/AIDS.

Overall it may be summarized that although the researchers view this work as a preliminary result from an ongoing research, it is obvious that a good percentage of the respondents have heard about HIV/AIDS. They differ greatly on how it can be contracted. The belief on witchcraft is very strong (19.7%) among respondents. They also believe that the HIV/AIDS caused by witches can be cured in the churches. However, sexual laxity (especially promiscuity) is known to be the main cause of HIV/AIDS among people in these communities.

Some respondents among women believe the sexual urge among their female folk is uncontrollable especially among their adolescents for reasons they cannot understand. A medical doctor at the University of Uyo Teaching Hospital says sexual activities are increasing daily among adolescents at Uyo leading to abortion and HIV/AIDS (Abasiattai 2007). We have also seen that there are socio-cultural practices that are possible causes of increasing HIV/AIDS that should not be ignored.

CONCLUSION

As mention earlier, the three-month research is the first of a long foreseen research on socio-cultural factors that lead to increasing HIV/AIDS among the people. It is the opinion of these researchers that attitude change based on this new knowledge can help to stem down the rate of infection especially among women. It is when individuals see HIV/AIDS as disease that could easily be contracted that they begin to take precautionary measures as was applicable in the leper colonies of the 1950s in Nigeria. The outcome of this research is indicative of the fact that people in Akwa Ibom now take these precautionary measures but more need to be done.

RECOMMENDATIONS

1. There is need for intensive awareness campaign in the communities to drum to the ears of the people the reality of HIV/AIDS and the need to control it.
2. There is need to educate the communities through billboards, film shows et cetera about the socio-cultural practices that can make members of the community to contract it.
3. All efforts should be made to reduce the stigma emanating from the scourge. If the stigma is not reduced, the AIDS sufferers may go underground and spread it further.

NOTES

1. Dr. Martin Akpan made the statement that Akwa Ibom State takes second position in terms of HIV/AIDS pandemic with 8.0 sero-prevalence rate out of the 36 states in Nigeria; in his speech at Akwa Ibom State HIV/AIDS summit: Theme: walk in safety, know your status held at Ibom Hall; Uyo 11th April, 2007.
2. Nigeria ranks 4th in the world with a prevalence rate of 4.4%. Akpan, Martin (2007) Intercourse of creativity: Nigerian artists and HIV/AIDS. SACA News April/May, 2007. P.5.

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