

# Socio-Economic and Cultural Practices affecting the Spread of HIV/AIDS in Abia State, Nigeria

Alamba, C.S<sup>\*</sup>, Odoemelum, L. E<sup>\*\*</sup>, Lekan-Akomolafe, C. N<sup>\*\*\*</sup>

<sup>\*</sup>Department of Agribusiness and Management

<sup>\*\*</sup>Department of Rural Sociology and Extension

<sup>\*\*\*</sup>Continuing Education Center

Michael Okpara University of Agriculture, Umudike, Abia State, Nigeria

## ABSTRACT

The study investigated some socio-cultural factors affecting the spread of HIV/AIDS in Abia State, Nigeria. Upon all the efforts of Nigeria government in the control of the epidemic through multi-sectoral approaches, the HIV/AIDS prevalence rate is still very high. The study therefore tried to investigate some of the socio-cultural practices that can cause the spread of the epidemic. One hundred and twenty respondents were purposively selected from Abia central because they met the criteria stipulated for the study. Multi-stage sampling procedure was used in the selection of the sample size. In the first stage, 6 communities were randomly chosen, followed by a random selection of two villages and 10 households from each village, bringing the total to 120 respondents. Both primary and secondary data were used to source for relevant information and subsequently analyzed with both descriptive and inferential statistics. The results indicated some socio-cultural practices that aid in the spread of HIV/AIDS. These include spouse inheritance, female genital mutilation, polygamy, circumcision, tribal mark incision and bride wealth with the following mean score 2.7, 2.65, 2.45, 2.60 and 3.32 respectively. Though a lot of effort has gone into eradicating some of the negative practices, there are strong indications that these practices are still going on among communities and families. The study therefore recommends that, as a cross-cutting intervention, more information will be required, using a combination of both interpersonal and other forms of communication, with messages specifically highlighting the relationship between each of the traditions affecting the spread of HIV/AIDS epidemic in the area.

**Keywords:** *Socio-cultural Factors, Community, HIV/AIDS and Abia*

## 1. INTRODUCTION

More than twenty years after AIDS was first diagnosed, it has become one of the most devastating disease faced by humanity, sticking on average, 14,000 men, women and children daily, and is considered to be one of the leading cause of death in sub-Saharan Africa and the World's fourth biggest killer. AIDS poses a great threat to development prospects in poor countries than any other disease with the impact said to be hardest among the poor, who are the weakest social support of any group with no economic strength to cushion the impact of the disease (UNAIDS, 2002).

The spread of the epidemic have pointed to a range of socio-economic factors which include the worsening economic conditions and general breakdown in the social and health care system. Others include general low levels of health, compromised immune systems, high incidence of other infections, including genital infections, exposure to disease such as tuberculosis and malaria, inadequate public health services, illiteracy and ignorance; pressures encouraging high-risk behavior, from labour migration to alcohol abuse and gender violence, and inadequate leadership response to either

HIV/AIDS or the problem of the poor; and finally, lack of confidence or hope for the future (Epstein, 2002). Though generally a global problem, the statistics presented during the past 24 years tend to suggest that Africa and Nigeria in particular is at the epicenter of the disease. Epidemiological data (US Census Bureau, 2008) carried out in Nigeria indicated that Nigeria was steadily increasing throughout the 1990s. The difference between HIV sero prevalence in urban and rural areas was not large. According (Obi *et al.*, 2010) there is considerable variation in the urban/rural prevalence of HIV/AIDS among the states in Nigeria. In some states, urban prevalence figures are higher than that of the rural, though the reverse is the case in others. For 2008, the estimated adult HIV prevalence is 5 percent. HIV sero prevalence varied in each geopolitical zone by State, Akwa Ibom and Cross River had the highest rate in the South-South zone at 8 percent and 6 percent respectively, the seroprevalence ranged from 4 percent in Imo, 7.7 percent in Abia and nearly 7 percent in Enugu (UNAIDS, 2008).

Communities believed to be only marginally affected by HIV/AIDS may appear so only because there are no sentinel sites or other monitoring mechanism in place. The spread of AIDS follows a different pattern in each village and LGAs. Geographic



and ethnic factors, agro-ecological conditions, religion, gender, age, marital status and peoples perception about the disease play a role in the pattern and impact of HIV/AIDS (UNDP, 2008). Odoemelam (2010) cited that even within one community, two villages can have markedly different agro-ecological conditions and customs that determine sexual behavior and attitudes towards HIV/AIDS

As many groups have pointed out, (FAO, 2003, CTA, 2004, LEISA, 2007) there is no doubt about economic short comings as determinants of the high rate at which this deadly disease spreads. However, there is also evidence that some negative cultural beliefs, traditions and practices, which are deep rooted in the social and sexual lives of most Nigerian ethnic groups have also contributed to the transmission of the disease. The activities through which society defines and identifies itself are unique but many and vary from society to society. These activities manifest themselves through values, norms, beliefs and practices which may have positive or negative implication for well or otherwise of the population, some cultural norms and practices relating to sexuality contribute to the risk of HIV infection. In case of Abia, our investigation brings out two categories of culturally – defined and instigated sexual patterns and social relations which can be associated with HIV transmission and the spread of AIDS. The first category consists of a set of social or sexual traditions and practices which are an outgrowth of beliefs related to a perceive role or roles and/or responsibilities of an individual in a social relationship, such as marriage union. In this classification are found puberty rites (initiation ceremonies) ‘dry sex’ and the general use of herbs to boost sexual performance, polygame and circumcision rituals. The second category consists of social relations based on tradition which dictates that something has to be done in a particular way simple because it has been done like that for years. These include property right and wife inheritance which embraces the habit of having a sexual relationship with a young sister of the wife as a way of anchoring the old relationship (CTA, 2002).

The medical and public health communities cannot hope to lead such a campaign alone. Nor is it possible to expect those already gravely ill with complications of HIV infection to go alone.

Though steps have been taken to eradicate these socio-economic and cultural practices from modern Nigeria, social life, especially in light of the AIDS pandemic, there are traces suggesting that such habits are still a part of Nigerian life, albeit in varying degrees. Therefore, the study tried ascertain the impact of these socio-economic and negative cultural practices on the spread of the HIV/AIDS epidemic with the following specific objectives to;

1. Ascertain the socio-economic characteristic of the respondents

2. Identify the sources of HIV/AIDS messages accessible to them.
3. Identify their level of awareness of the epidemic
4. Ascertain their level of knowledge on ways HIV/AIDS spread
5. Identify respondents level of knowledge on how HIV/AIDS epidemic can be controlled
6. Identify the cultural practices that influences the spread of HIV/AIDS in the study Area.
7. Determine the socio-economic factors that affect the spread of the epidemic.

## 2. METHODOLOGY

### The Study Area

The study was carried out in Abia State. Abia State is made up of three senatorial zones namely Abia North, Abia Central and Abia South. Out of the three zones, one zone (Abia central) was selected for the study. From this zone, one Local Government Area, (Obingwa, L. G. A.) was purposively selected, because it met the criteria stipulated for the study.

Multi-stage sampling procedure was used in the selection of the sample sizes. In the first stage, 6 communities were randomly chosen, followed by a random selection of two village each from those communities. From these villages, 10 households were randomly selected, bringing the total to 120 respondents. Both primary and secondary data were used to source for relevant information for the study and subsequently analyzed with the use of both descriptive and inferential statistics. Objective 1 – 5 were analyzed with the use of simple descriptive statistics and a ranking order of analysis was used to capture objective 6, the questions were designed in a 3-point Likert’s scale using values 3, 2, and 1.

Agreed 3  
Undecided – 2  
Disagreed 1  
Total 6

The total score for ranking was 6. The cut-off point was established by finding the mean value.

$$X = \frac{\sum x}{n}$$

Where  $\bar{x}$  = mean of values

$\sum x$  = summation of values

N = number of ranking

$$\therefore \bar{x} = \frac{3+2+1}{3} = 2$$

0.05 significant level was used to determine the interval scale of the population parameter. The upper limit of the scale is  $2+0.5 = 2.05$ . The implication is that any number that fell between 1.95 to 2.05 is for undecided, 1.95 and below will be for disagreed while 2.05 and above accounted for agreed. Objective 7 was released with simple regression analysis. The explicit form is stated below.

$$Y = F(X_1, X_2, X_3, X_4, X_5 + e)$$

Where Y (Dependent variable) socio-economic and cultural determinant of the spread of HIV/AIDS.

$X_1 - X_6$  (independent variables)

Where

$X_1$ : Marital status; dummy variable; ever married 1; single 0.

$X_2$ : Age measured in years as supplied by the respondents.

$X_3$ : Education, Number of years of formal education

$X_4$ : Income, Measured in Naira from major occupation.

$X_5$ : Household Size – total number of people in a household.

$X_6$ : Poverty dummy viable; Not poor 1; Poor 0

e – error term

### 3. RESULTS AND DISCUSSION

#### Socio-Economic Characteristics of the Respondents

Results on table 1, indicated that about (34%) of the respondents fall within the age bracket of 30 – 35 years age. This is a very active age for both reproductive and productive activities. From the table also most of the respondents (79%) were married while (21%) of them were single. According to one of the respondents, “Bride wealth, which has become unaffordable for many young men these days, and the breakdown of the institution of marriage are contributing to a growing number of informal union between men and women, exposing them to heightened risk. According to Garcia – Moreno and Watts, (2000), for many women, economic dependency and social vulnerability lead to the daily terror of physical abuse at the hands of spouse or partners. According to Dada-Adegbola (2004) certain socio-cultural knowledge and religious practices such as polygamy and giving a daughter away in marriage without social life of the man are likely contributory factors to the higher prevalence of HIV/AIDS in women in this part of the world. There is therefore the need to enact law on pre-marriage. HIV screening for intending couples. Table 1; further revealed that about 38% of the respondents had no formal education while the remaining (62%) had various forms of educational attainment. The increase in drop out school rates have contributed to the creation of a high risk environment for rural young men and women. The resulting increase in poverty and illiteracy, and the erosion of social values and family life education act as catalyst to high risk sexual behavior. Stopping HIV/AIDS will require exposing socio-economic

structures that often curtail people’s options for avoiding exposure to the virus and using education empowerment and social change to loosen those constraints. The table 1 also further shows that majority of the respondents earn below (N10,000) per annum. Inequality in the distribution of wealth and social poverty limits people’s option for protecting themselves and force them into situation of lightened risk (Oxfam, 2005). This will restrict their abilities to make sound choices about sexual practices.

#### Awareness of HIV/AIDS of the Respondents

It was found that majority of the respondents (90%) has heard about the epidemic while a small percentage (10%) claimed to be ignorant of it. Also about (66%) of the respondents claimed to be not aware of the mode of transmission. On how to control the epidemic, (28%) claimed to know how it could be controlled while (94.2%) stated that they have not heard. The implication is that, since majority of the respondents have not heard of ways of controlling the epidemic, may be, because of the cultural background, there is every tendency for the increase of the epidemic in the study area. According to (Irwin et al., 2003) among the greatest HIV/AIDS is misinformation about the pandemic. They further explained that people must have sound knowledge because ignorance breeds passivity, pessimism, resignation, or a sense that AIDS is someone else’s problem.

#### Knowledge on Sources of HIV/AIDS Spread

The respondents were asked to state ways HIV/AIDS could spread, about (62%) claimed that one contract the epidemic through sexual intercourse with affected person. Sex work or sexual transactions that are poverty driven are likely to foster behavior that are risk-taking, which encourages unprotected sex to be more prevalence, thereby increasing the spread. About (60%) of the respondents understood that HIV/AIDS can be spread through the use of clippers and razor blade and unsterilized needles used by affected people. The use of one instrument by a group for these activities may lead to HIV infection. The assumption that (0 – 80%) of the Nigerian men and women are aware of HIV/AIDS and know how to protect themselves (Hodges, 2001), does not apply to the rural areas visited for this study. The implication is that the less people know about the disease the more negative they tend to be about HIV and AIDS afflicted and affected families. About 40% of the respondents stated that one can contract HIV/AIDS through mosquito bite while 33% did not react to that. Further more 35% of the respondents claimed that one can be infected by eating with an infected person.

#### Socio-economic and Cultural Practices that Aids in the Spread of HIV/AIDS Epidemic

Results on table 4, indicated the respondents negative practices that fuel the spread of HIV/AIDS. Generally, the mean score



values of each of the cultural factors presents in table 4, exceeded the upper limit scale of 2.05 which implies that there is a general agreement that these factors contributed greatly to the spread of the epidemic. Spouse inheritance (2.75) mean score, is a cultural practice which promotes the exchange of sexual partners after a death in a family. In its formal sense, it involves marrying of the surviving partner to a relative of the deceased which as (Ekong, 2008) says about most tribes in Nigeria was traditionally meant to ensure that there is continuity of the family, its reproductive role and to ensure proper care of the minor children of the deceased. Among the Ngwa communities in Abia State, the practice is very common, a younger brother or cousin of the deceased would take over the widow and most of the property of the deceased soon after burial. The practice was also observed among other tribes in the state. From the table also, polygame with mean score of (2.60) in spite of the dangers it poses in this era of HIV/AIDS, is still wide spread and affects every level of Nigerian society. Given the evidence that having many sexual partners increases one's chances of being exposed to HIV, polygame and extra marital affairs, both of which are culturally tolerated, play a part in trying to understand the prevalence of HIV/AIDS in Nigeria. Female genital mutilation (2.45), tribal mark incision (2.50) increases the spread of the epidemic as they share the same mode of transmission (Hodges, 2001). The use of one instrument by a group for these activities may lead to HIV infection. In the fight against HIV/AIDS, these socio-cultural forces must be taken into consideration. Circumcision with mean (2.32) is a common cultural practices among the respondents. The cultural practice of male circumcision also has implication for HIV infection when carried out with contaminated instruments. It has been described as the surgical removal of some or of the foreskin (or prepuce) from the penis. Bride wealth (2.65) which has become unaffordable according to the respondents these days, especially in the eastern part of the country, and the breakdown of the institution of marriage are contributing to a growing number of informal union between men and women, which deprive them of legal and socio-economic rights and status.

#### Respondents Sources of HIV/AIDS Information

Results on Table 5, shows respondents sources of information. The result reveals that about 42% of the respondents receives HIV/AIDS information through Radio and Television, followed by friends and relatives and religious leaders. The high percentage on radio and television can be attributed to its larger coverage and religious leaders because of their moral preaching to stop the spread.

#### 4. CONCLUSION

The cases of cultural practices suggests that, though a lot of effort has gone into eradicating some of the negative practices, there are strong indications that these practices are still going on

among communities and families. In other cases, especially in the remote areas, it would appear that these traditions are carried out either from lack of accurate information about the relationship of each or one of them to HIV transmission or simply due to lack of information altogether. Improving public awareness on the use of safer sex practices in order to stop the transmission of HIV and sexually transmitted disease.

Most of the respondents were still in their active productive and reproductive age, with low educational attainment and low income and large household size. About 90% of the respondents have heard about HIV/AIDS while 66% of the respondents claimed unaware of mode of transmission. There sources of information on HIV/AIDS is among cultural practices that aids the spread includes polygamy, spouse inheritance and bride wealth.

#### 5. RECOMMENDATION

- As a cross-cutting intervention, more information will be required, using a combination of both interpersonal and a combination forms of communication, with messages specifically highlighting the relationship between each of the traditions affecting HIV/AIDS. More information is recommended because, as many of the respondents suggested, the perpetuation of some of the practices is based on lack of information relating these practices to the prevalence of HIV/AIDS. Also given, that most of the mass media sources of information hardly reach the rural population, the use of local media such as theatre, puppetry, drama and open meetings is suggested, particularly by rural based home-care givers. A part from the information intervention, the paper recommends for either total alternation or abolition of some of the cultural practices using the judicial system.
- Prevention activities should be integrated in to mainstream health programmes and other programmes dealing with communities. Effective behavior change strategies need to involve the communities itself in the generation of appropriate messages and should address specific socio-economic and cultural realities that influence sexual behavior. The social-cultural norms to be addressed include wife inheritance.

**Table 1: Distribution of Respondents according to their Socio-economic Characteristics**

Variables	Frequency	Percentages
<b>Age</b>		
20 – 25	35	29.1
30 – 35	41	34.2
40 – 45	20	17.0
50 – 55	14	12.0
60 – 65	10	8.3
<b>Total</b>	<b>120</b>	<b>100</b>
<b>Sex</b>		
Male	58	48.3
Female	62	51.7
<b>Total</b>	<b>120</b>	<b>100</b>
<b>Marital Status</b>		
Ever married	95	79.2
Single	25	21.0
<b>Total</b>	<b>120</b>	<b>100</b>
<b>Educational level</b>		
Non formal	45	37.5
Primary education	29	24.2
Secondary	28	23.3
Tertiary	18	15.0
<b>Total</b>	<b>120</b>	<b>100</b>
<b>Income level (‘N,000)</b>		
10 – 20,000	58	48.3
30 – 40,000	42	35.0
50 – 60,000	20	46.7
70 – 80,000	-	-
<b>Total</b>	<b>120</b>	<b>100</b>
<b>Household</b>		
2 – 4	24	20.0
5 – 7	34	28.3
8 – 10	58	48.3
11 – 13	4	3.3
<b>Total</b>	<b>120</b>	<b>100</b>

Source: Field Survey, 2011

**Table 2: Distribution of Respondents Based on Awareness of HIV/AIDS (N = 120)**

Awareness of HIV/AIDS	Yes Freq.	Yes %	No Freq.	No %
Heard of HIV/AIDS	108	90	12	10
Heard of mode of transmission	41	34.2	79	65.8
Heard of how it could be controlled	32	27.6	88	73.3
Heard of anti-retroviral vaccine	7	5.8	113	94.2

Heard of condom use 72 60 48 40

Source: Field Survey, 2011

**Table 3: Distribution of Respondents on their knowledge of Sources of HIV/AIDS Spread**

Model of Spread	Yes		No		No response	
	Freq.	%	Freq.	%	Freq.	%
Sexual intercourse	74	61.6	16	13.3	30	25
Blood transfusion	52	43.3	48	40	20	16.7
Unsterilized needle	72	60	30	25	18	15
Sharing blade & clippers with infected person	72	60	4	3.3	44	36.7
Mosquito bite	48	40	30	25	42	33
Eating with infected person	42	35	64	53.3	14	11.7

Source: Field Survey, 2011

**Table 4: Distribution of Respondents on Socio-economic and Cultural Practices that Aids in the Spread of HIV/AIDS**

*Cultural Factors	Total Score	Mean Score	Remark
Spouse inheritance	330	2.75	Agreed
Female genital mutilation	294	2.45	Agreed
Polygamy	312	2.60	Agreed
Initiation ceremony	268	3.32	Agreed
Tribal mark incision	300	2.50	Agreed
Bridal wealth	318	2.65	Agreed
<b>Total</b>	<b>1822</b>	<b>15.18</b>	<b>Agreed</b>

\*Multiple response

Source: Field Survey, 2011

**Table 5: Distribution of Respondents on Sources of Information on HIV/AIDS**

Sources of Information	Frequency	Percentages
Social groups	12	5.0
Parents	18	7.3
NGOs	-	-
Religious leaders	38	16.0



<http://www.esjournals.org>

Extension Workers	14	5.7
Teachers	-	-
Radio/TV	102	42.0
Newspaper	13	5.3
Friends/relative	48	19.6

Multiple response

*Source: Field Survey, 2011*

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