

## Socio-Cultural Factors Influencing HIV/AIDS Prevalence in Nigeria; A Review

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### ABSTRACT

The Acquired Immune-deficiency Syndrome (AIDS) is predominantly a sexually transmitted disease. Medical scientists agree that Human Immune-deficiency virus (HIV) cause the syndrome. Presently, 80% of HIV positive people in Africa acquired it sexually while 10% acquire it through blood transfusion. The remaining 10% acquired through mother to child transmission, and contamination with infected materials like shaving blades, injection needles, invasive objects, and devices. The new face of Human Immune Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) has earned it recognition as a social problem due to the associated devastating social and cultural consequences on individuals and the society. As such, the pandemic needs to be given adequate social and cultural exploration for designing effective prevention program. This becomes important, as there may be cultural variations that need to be understood before an effective program could be designed. The objective of this review was to determine the socio-cultural factors associated with HIV/AIDS transmission. The review was conducted using PEN-3 Cultural model as a guide. Electronic search of published literature in Pub Med, Medline and national HIV sero-prevalence sentinel survey 2010 was used. The bulk of the secondary data was sourced from the reports of the Federal Ministry of Health, National Agency for the Control AIDS and the National Population Commission of Nigeria. Findings indicated gender inequalities, polygamous marriage, early marriage, widow inheritance, multiple sexual practices, alcohol/drug, harmful cultural/traditional practices, stigma, and taboo as factors promoting HIV/AIDS prevalence in Nigeria. Data from the national sentinel survey was used to produce various graphs to show the trend of HIV/AIDS at the national, state, urban, and rural areas across different age groups. HIV/AIDS is a social problem associated with human developmental process and interventions should focus on the entire societal development. Education and mass enlightenment are invaluable tools in achieving the desired goals to stem the tide.

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### Introduction

HIV/AIDS was first identified in Nigeria in 1985 and reported in 1986 and is predominantly transmitted through sexual contact.<sup>1, 2</sup> It has since posed a barrier to development as 170,000 Nigerians died from AIDS in 2007<sup>3</sup>, and since then, the HIV and AIDS epidemic has continued to spread. In 1991, the country initiated a HIV sero-prevalence sentinel survey among the antenatal clinic attendees; the survey commenced with a few states and progressively expanded until all the states became involved by 1999.<sup>4</sup> The Ante Natal Clinic (ANC) biological survey conformed the first generation surveillance system. It determined HIV prevalence among the sentinel population at fairly regular and short intervals and was used to track the trend and distribution of the HIV epidemic across the country. HIV prevalence obtained from the ANC survey was used to estimate the prevalence in the general population. The 2010 round of the ANC HIV sentinel survey was the ninth in the series in Nigeria. In 2008, the survey included the simultaneous collection of data from the prevention of mother to child transmission HCT/PMTCT

services of the participating sentinel sites for the purpose of comparison with the ANC survey data repeated in 2010.

The country has already passed the 5% explosive prevalence phase thus far. The disease has killed more than 1.3 million and orphaned over 1 million children.<sup>5</sup> The main mode of HIV transmission in Nigeria is largely through unprotected heterosexual sex. Factors such as poverty, sexually transmitted infections (STIs), social and religious norms, and political and social changes (e.g., labour migration) contribute in promoting the pandemic in Nigeria.<sup>6</sup>

### Methods

The review was conducted using PEN-3 Cultural model as a guide, electronic search of published literature using Pub Med database, Medline and data collected from national HIV sero-prevalence sentinel survey 2010. The bulk of the secondary data used in this study was also sourced from the reports of the Federal Ministry of Health, National Agency for the Control AIDS and the National Population Commission of Nigeria.

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## Results

Findings indicated that gender inequalities, polygamous marriage, early marriage, widow inheritance, multiple sexual practices, alcohol/drug, harmful cultural/traditional practices, stigma, and taboo influence HIV/AIDS prevalence in Nigeria. Data from the national sentinel survey was used to produce various graphs to show the trend of HIV/AIDS at national level, state level, urban and rural areas and various age groups. HIV/AIDS is a social problem associated with human development process, thus solutions to the problem should focus on the entire development of the society. Necessary to understand are various socio cultural factors of HIV/AIDS highlighted with the view of educating the people.

### Nigeria HIV/AIDS Epidemic

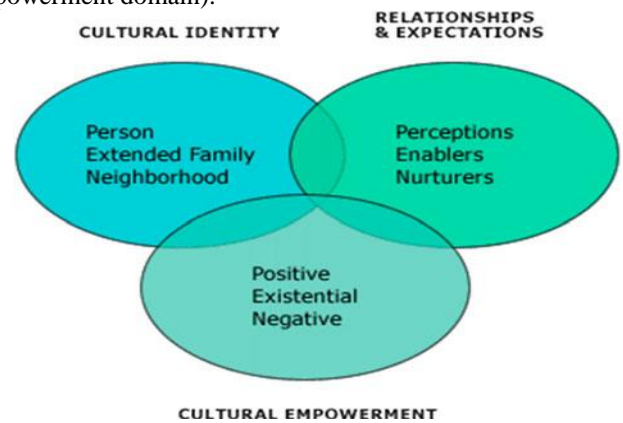
Nigeria is the most populous black nation in the world and a very prominent country in the African continent. It is believed, based on the country's population of 140 million<sup>7</sup> that for every five Africans, one is a Nigerian. By the year 2005, the sub-Saharan Africa where Nigeria rightly belongs, had about 25.8 million people living with HIV/AIDS.<sup>8</sup> In 2005 alone, there were about 3.2 million newly infected AIDS cases with seven point two percent sero-prevalence rate and 2.4 million deaths.<sup>9</sup> Since the first case of AIDS in Nigeria was reported in 1986, the HIV and AIDS epidemic has continued to evolve. 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 but currently, Nigeria ranks 4th in the world with a prevalence rate of 3.6%. Since the first case of AIDS in Nigeria was reported in 1986, the HIV and AIDS epidemic has continued to evolve. The first sentinel surveillance survey showed HIV prevalence rate of 1.8% in 1991. Subsequent sentinel surveys showed increasing prevalence rates of up to 5.8% in 2001 and then a decline to 4.4% in 2005. However, the 2008 prevalence of 4.6% showed a slight reversal in the downward trend, thereby generating some interest. The HIV epidemic, as monitored through prevalence rates, appears to show some consistency in the national trend; however, there has been wide variation across the states and sites with a number of consistent hot spots. While the prevalence has shown a consistent decline in some states, it has been fluctuating in others except Benue State with consistent rise. Since 2003, all the States in the country have had a generalized epidemic.

Estimates from the 2008 ANC survey showed that 2.87 million persons were living with HIV in Nigeria. The survey also showed highest HIV prevalence among women aged 25-29 years (5.6%) followed closely by those aged 30-34 years (4.9%).<sup>10</sup> Educational status was a key factor in HIV prevalence in Nigeria. In 2007, the national population-based survey showed an overall HIV prevalence of 3.6% (4.0% among females and 3.2% males). Among the high-risk groups, female sex workers constituted an important reservoir of HIV infection for continuous transmission to the general population. HIV prevalence among this group has been on the increase since 1991 especially among brothel based female sex workers (FSW)<sup>9</sup>.

### Knowledge, Attitudes and Behaviours

AIDS cases are becoming very visible in Nigeria. About one out of every four persons in Nigeria had seen someone with HIV or known someone who died of AIDS. In addition, awareness of HIV and AIDS was generally very high (93.8%). However, correct knowledge of all the routes of HIV

transmission and two methods of prevention remained low (54% and 52.5%).<sup>11</sup> The use of condom in the last sex act was low (16%) despite the fact that sexual transmission is the predominant mode of HIV spread in Nigeria. The PEN-3 cultural model. It was developed by Airhihenbuwa, and addresses the role of culture in the adoption or non-adoption of health behaviors.<sup>12,13</sup> It consists of three domains namely: (see Figure1) Cultural identity, Relationships and Expectations, and Cultural Empowerment, which offer the opportunity to centralize culture in the development of health promotion interventions.<sup>14</sup> Each domain includes three factors that form the acronym PEN; Person, Extended Family, Neighborhood (Cultural Identity domain); Perceptions, Enablers, and Nurturers (Relationship and Expectation domain); Positive Existential and Negative (Cultural Empowerment domain).



**Figure 1. The PEN- 3 Cultural model**

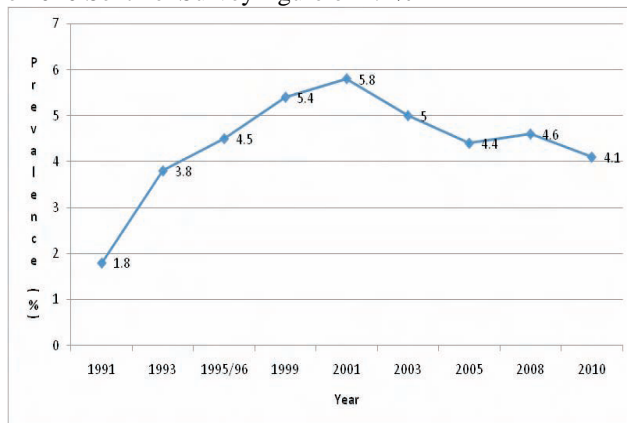
The PEN-3 cultural model also serves as a tool for examining the context that shapes the health behaviors of interest. This is achieved by highlighting the culturally relevant factors that are influential and are necessary for the development of effective and targeted health interventions.<sup>15</sup> Since inception in 1989, the PEN-3 Cultural Model has been used to conduct community-based research on HIV stigma in South Africa.<sup>16</sup> The focus of this study was on the Cultural Empowerment, well as Relationship and Expectation domain. Cultural positive refers to key values that promote awareness about HIV/AIDS. Existential are unique values practiced in the cultural societies that pose no threat to HIV program, while negative includes health beliefs and action that are harmful and negatively influence HIV/AIDS prevention.<sup>17</sup>



**Figure 2. HIV/AIDS and the Precipitating Factors**

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. According to National HIV/AIDS and Reproductive Health Survey (NARHS, 2012) data, the National HIV Prevalence showed a decline to 3.4%, indicating a reversal of the epidemic in the country, compared to the 2010 Sentinel Survey figure of 4.1%



**Figure 3. National HIV Prevalence Trend Analysis National HIV Prevalence Trend from 1991-2010 (HSS 2010)**

## Discussion

Social and cultural factors inevitably interact with society to impact health.<sup>18, 19</sup> This confluence of factors determines a person's experience, belief, thought and definition of health and illness. Culture contributes to the richness of human experience.

Socialization is thus, 'the means by which social and cultural continuity are attained'.<sup>20</sup> Socialization describes a process which may lead to desirable, or 'moral', outcomes in the opinion of said society. Individual views on certain issues, such as race or economics, are influenced by the view of the society and become a "normal and acceptable outlook or value to have within a society. Socialization is critical both to individuals and to the societies in which they live. It illustrates how completely intertwined human beings and their social worlds are. First, it is through teaching culture to new members that a society perpetuates itself. If new generations of a society do not learn its way of life, it ceases to exist.

Whatever is distinctive about a culture must be transmitted to those who join it in order for a society to survive. It is a combination of both self-imposed (because the individual wants to conform) and externally imposed rules, and the expectations of the others. Culture is the beliefs, customs, practice, and social behavior of a particular nation or people. It is also the shared beliefs and values of a group of people. "The spread of HIV is attributed to a wide range of factors, which include behavioural factors, the quality and access to services and programs aimed at prevention, care, social support and the mitigation of impact, as well as social and socio-economic factors."<sup>21</sup> The following socio cultural issues have been identified as playing major roles in the spread of HIV/AIDS prevalence in Nigeria.

### Gender inequalities

The level to which men and women control or influence the various aspects of their sexual lives e.g. ability to negotiate the timing of sex, conditions under which it takes place and the use of condoms, plays a critical role in determining their vulnerability to HIV infection.<sup>22</sup> People's control over their sexual lives and choices is shaped by gender-related values

and norms, which define masculinity and femininity. These culturally defined gender values and norms evolve through a process of socialization starting early stage of infancy. They determine and reinforce themselves through traditional practices such as wife sharing, widowhood related rituals, early marriage, and female genital mutilation and the condoning of gender-based violence. These cultural practices, values, norms, and traditions have strong influences on the visible aspects of individual behaviors and are important determinants of men and women's vulnerability to HIV. Personal risk of contracting HIV is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviors. Gender norms are deeply rooted in the socio-cultural context of each society and enforced by that society's institutions and practices.<sup>18</sup> Socio-cultural norms build notions of masculinity and femininity, which in turn create unequal power relations between men and women. This power imbalance affects women and men's access to key resources, information, and their sexual interactions. It curtails women's sexual autonomy and expands men's sexual freedom and control over sexuality. This results in their different vulnerabilities to HIV infection. The gender role prescribed for women, or 'femininity', demands a submissive role, passivity in sexual relations, and ignorance about sex. It also restrains women from seeking and receiving information related to HIV prevention.

In cultures where virginity is highly prized, young women attempt to preserve their virginity by practicing alternative sexual behaviors, such as anal sex, which increases their vulnerability to HIV. Gender inequality in marital relations, especially in sexual decision-making, increases vulnerability to HIV transmission.<sup>23</sup> Trends in current data on new HIV infections suggest that the incidence of HIV is rising among married women and girls worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among women. This results in women's increased inability to negotiate safer sex. Women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence.

### Polygamous marriage

The traditional practice of polygamy, which is legally sanctioned in some parts of the world, allows husbands to have more than one wife. This occurs despite international human rights instruments defining equality in marriage and family life through an equal rights and responsibilities framework<sup>23</sup>, violated in polygamous unions because wives have fewer de facto marital rights and their husbands fewer responsibilities.<sup>24</sup> Polygamy operates to create concurrent sexual networks within marriage between multiple wives and their husband, and in addition to any extra-marital sexual contacts, the spouse may have. Direct sexual transmission of HIV can occur in these concurrent sexual networks where the virus is introduced through the spouse's extra-marital sexual contacts or where a new wife who is already HIV positive enters the polygamous union.

Records show that about 9.9% of women and 9.0% of men in polygamous unions are HIV positive as compared to only 6.6% of women and 7.7% of men in monogamous unions being infected with HIV. A formal recognition of polygamous unions in various countries amounts to reinforcement of the patriarchal notion that women should passively accept their partners' sexual decision-making. It broadens the scope of

masculine sexual freedom. In addition to reinforcing patriarchy, studies have shown that the typically discordant nature (relationships that are characterized by friction and disagreement) of polygamous co-wives and husband-wife relationships also aggravates domestic violence. These strong patriarchal notions increase the risk of HIV transmission by undermining women's ability to negotiate condom use, to insist on partner fidelity, and to leave high-risk sexual relationships. Negotiating safe sexual practices and insisting on partner fidelity becomes further complicated in polygamous households given that multiple wives are often reliant on one husband for material survival. The economic hardship and lack of emotional attention associated with polygamy can lead women to engage in extramarital sexual relationships.<sup>25</sup>

#### **Widow Inheritance**

Widow inheritance refers to a practice of a brother of a deceased husband or close relative to inherit the wife of the deceased. Explanations from opinion leaders show that inheritance is practiced to ensure a continuous support and care of the wife and children of the deceased husband. On the other hand, there are arguments that there is possibility for the widow (wife of the deceased husband) to get married to another person outside the clan of the deceased, or she may decide to go back to her parents or other relatives. This situation implies a loss of the paid bride price on the side of the deceased husband. Hence, inheritance of widow is sometimes taken as a strategy to compensating the paid bride price, otherwise the parents of the widow are required to return the paid bride price and allow their daughter (widow) to go back home or get married again. There are also some arguments that a man is a bread earner, so all the available properties are a contribution from the deceased husband. This validates the rationality of a widow being inherited by a close relative of a diseased husband and this increase the risk of HIV vulnerability.

#### **Alcohol and drugs**

"Substance abuse is well known as contributing to impaired judgment and the need to support the individual's addiction creates vulnerability to commercial and unprotected, casual, and non-consented sex."<sup>26</sup> In a study done by the Division of Health Sciences Education and the bilateral Public Health Strengthening in Guyana Program, 172 persons from across the country were interviewed and 90% of them used cocaine on a daily basis. In addition, 88 percent had used alcohol with that same percentage having used marijuana. In this study, 13.4% were commercial sex workers.

#### **Multiple sexual practices**

Gender inequality and patriarchy (social structures where men take primary responsibility and dominate in their households) encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. In a study in Zimbabwe, one in eight married men said they had casual sex (more than one sexual partner in the previous twelve months), but only one in one hundred women said they had sex outside marriage.<sup>27</sup> In these circumstances marriage puts women at the greatest risk of HIV infection instead of protecting them. With lack of knowledge of HIV and reluctance to use condoms, these practices put men and their male and female partners at risk of HIV. In this context, the dangers of multiple sexual partners relates to the fact that

if one person in a 'circle' of partners gets infected with HIV, there is a very high likelihood that all persons involved will become infected.<sup>28, 29</sup>

#### **Early Marriage**

The majority of sexually active girls aged 15-19 in developing countries are married.<sup>18, 19</sup> Child marriages (marriage before age 18) remains a fact in South Asia, portions of Latin America, and many sub-Saharan African countries.<sup>30</sup> Eighty-two percent of girls in Niger, seventy-five percent in Bangladesh, sixty-three percent in Nepal, fifty-seven percent in India and fifty percent in Uganda marry before the age of 18. If the present trend continues, over 100 million girls will be married worldwide before the age of years in the next decade. Early marriage severely increases young girls' vulnerability to HIV, as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer vaginal membranes, which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married girls' exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex.<sup>10</sup> The significant age gap in spouses further intensifies the power differential between husband and wife. It discourages the open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing test results and planning for safe sexual relations throughout the marriage. Early marriage also curtails girls' socio-economic development and results in their social isolation, which is increasingly identified as a predisposing factor for HIV risk. This is because it curtails the social contacts and networks that play a vital role in transmitting HIV prevention information and supporting behavior change. Girls who are married at an early age also have low educational attainment and limited or no schooling options, limited control over resources, and little or no power in their new households. Child marriage is a violation of human rights as it violates the right to freedom and growth of children. Gender inequality is both a cause and a consequence of child marriage.

#### **Harmful Cultural and Traditional Practices**

Harmful cultural practices such as widowhood-related rituals, sexual cleansing, and female genital cutting heighten the risk of HIV transmission. These practices are often justified in the name of cultural values and traditions. No doubt, cultural values and traditions are important to community identities, but it is important to realize that they cannot be continued at the cost of the right to health of the individual.<sup>21</sup> Female Genital Cutting between 100 and 140 million women and girls have undergone mutilating operations on their external genitalia, suffering permanent and irreversible health damage. Every year, two million girls are subject to mutilation, which traditional communities call "female circumcision" and the international community terms "female genital mutilation" (FGM), or "female genital cutting" (FGC). According to WHO, FGM/FGC comprises all procedures involving partial or total removal of the external genitalia or injury to the female sexual organs.<sup>31</sup> This could be for either cultural, religious, or other non-therapeutic reasons. FGC is practiced in a large number of countries and cultures. FGC/FGM places girls and women at increased risk of HIV infection through several routes.<sup>32</sup> Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus

from one girl to the next. Secondly, FGM renders the female genitals more likely to tear during intercourse example of gender-based discrimination and a violation of the right to health. Gender-based violence has become commonplace in almost all societies. Acts of violence greatly increase Vulnerability to HIV.

Gender based violence is a violation of human rights and is identified as such by international human rights treaties. Violence increases vulnerability to HIV infection in several ways. Sexual violence can result in 'direct transmission' of HIV, which can be the result of forced or coercive sexual intercourse with an HIV infected partner. The type of sexual exposure (vaginal, anal, or oral) determines the biological risk of transmission in a violent sexual encounter. Risk of direct transmission in forced and coerced sexual encounters is also dependent upon the degree of trauma, such as vaginal or anal lacerations and abrasions, which occurs when force is used. For example, where sexual violence occurs in girls and young women, risk of transmission is likely to be higher because girls' vaginal tracts are immature and tear easily during sexual intercourse. Sexual violence can also result in 'indirect transmission' of HIV infection among women or men violence or the threat of violence affects the individual's power and ability to negotiate the conditions of sexual intercourse, especially condom use.<sup>33</sup> Several studies highlight that men's use of violence is linked to their own sexual risk-taking. Violence or the fear of violence is also considered a barrier to women seeking HIV testing, and for those who seek testing it acts as a barrier to disclosure of their HIV status to their male partners.

#### **Stigma and Taboos**

Cultural stigma and taboos (social bans), especially those related to sex and sexual activities, increase men's and women's vulnerability to HIV. The taboos associated with sex and knowledge of sex act as barriers to seeking knowledge of HIV prevention and to providing the treatment care and support needed by those infected and affected by HIV.<sup>16</sup> HIV-related stigma is triggered by many forces such as a lack of understanding of HIV, myths about how it is transmitted, prejudice, lack of treatment, irresponsible media reporting, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use. HIV and AIDS possess all the characteristics associated with stigmatized diseases. AIDS is incurable, degenerative, and fatal. HIV infection has come to be associated with socially condemned sexual behaviors and drug use for which individuals are often considered responsible. Besides the stigma, arising out of connotations of immorality associated with HIV and AIDS, ignorance about the disease generates stigma. HIV-related stigma can be described as a "process of devaluation" of people either living with or associated with HIV and AIDS. The stigma often stems from the underlying stigmatization of sex and intravenous drug use. Two of the primary routes of HIV infection HIV- and AIDS-related stigma and discrimination can take the form of anger and negative feelings towards people living with HIV (PLHIV), avoidance, ostracism, expressions of blame and shame. These are expression of belief that they are responsible for their condition and deserve it. Loss of livelihood, housing, physical, and emotional abuses, and disruption of family relationships have been reported.

Population based studies have shown that gender clearly plays a role in the nexus between HIV and AIDS and related

stigma. Women are much more stigmatized than men when they are infected. This is because there is close association in many cultures between HIV and sex and hence moral impropriety, and women in most cultures are expected to uphold and preserve the moral values of their communities. In these circumstances, HIV is regarded as evidence that they have failed to fulfill their social duties. The stigma and discrimination based on HIV status, in combination with deeply rooted stigmatizing attitudes and discriminatory practices towards women and girls, gay men and other MSM, transgender people, sex workers, and drug users, among others, creates conditions for HIV to flourish. For example, fear of stigma and discrimination prevents people vulnerable to HIV from seeking testing. Ignorance about one's HIV status increases the person's and their intimate partners' vulnerability to HIV infection. Fear of stigma and discrimination also adversely affects people's ability and willingness to disclose their positive test results to others. Stigma is linked to power and domination throughout society as a whole. Ultimately, stigma creates and is reinforced by social inequality.

#### **Religion**

Religion and religious beliefs are the foundations of community life in a majority of societies. Religion prescribes ethical guidelines for many aspects of daily life and navigates belief systems and norms surrounding sexuality. The majority of religiously tailored belief systems condemn premarital sex, contraception including condom use, and homosexuality. Some religions also advocate a submissive role for women, foster gender inequality in marital relations, and promote women's ignorance in sexual matters as a symbol of purity. The sexuality and gender stereotypes constructed by religion can inhibit prevention efforts and increase vulnerability to HIV infection. HIV vulnerability caused by religious beliefs and practices is the result of religious institutions' denunciation of HIV infection as sinful. Such religious judgments play a significant role in generating HIV- and AIDS-related stigma, which increases vulnerability. The religious construction of sexuality, with its emphasis on virginity, has led women to engage in anal sex in an attempt to preserve their virginity, which also increases their vulnerability to HIV.

Research has shown that religion also influences men's and women's exposure to HIV prevention messages, knowledge and perception of risks, and the practice of prevention. Women have been found to be disadvantaged in seeking information about HIV/AIDS due to their religious beliefs. Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. Similarly, religions that denounce homosexuality tend to fuel stigma against those who engage in same sex behavior, thus indirectly increasing their vulnerability to HIV. Religion, in spite of being a social determinant of vulnerability, has great potential for preventing HIV and reducing HIV- and AIDS-related stigma. Because of the influence, religious leaders have on the community, they can play a significant role in behavior change interventions, including the promotion of condom use, to reduce HIV transmission and de-stigmatize HIV and AIDS.

#### **Influence of poverty on HIV/AIDS**

Sixty seven percent of the identified PLWAs are rural migrants to urban communities. Rural poverty drove them away from their rural communities to search for employment

in urban areas they migrated to the cities to secure a living. As there are no secured jobs in the cities, 92% of the migrants engage in menial jobs. Men have more access to menial jobs than women do, because there are more of such jobs, which the society ascribes to men than those available for women. Men engage in bus conducting, driving, and other artisans upon migration to cities. This predisposes young women to engage in sex to augment their meager earnings, and sometimes as a means of livelihood pending when descent job would open for them. They eventually become commercial sex workers, a condition that makes them vulnerable to HIV/AIDS. Even men who engage in those menial and strenuous economic activities regard sex as a means of cooling down the stress from their menial engagements. This implies that because of women's inaccessibility to many jobs in the cities, they are more prone to some behaviors, which make them vulnerable to HIV/AIDS infection. Poverty also makes it difficult for the people to use condoms to protect themselves against the infection. Due to poverty, when infected with sexually transmitted diseases they lack resources to visit clinics. In Nigeria, primary health care does not provide reproductive health care services freely. Due to stigmatization, the victims of sexually transmitted diseases prefer treating their ailment secretly. They therefore depend on medical quacks and self-medication. A key informant, people living with AIDs (PLWA) reported as follows, "*When I got to Ibadan, I was learning hairdressing. But my sister I was living with did not give me transport money. A man used to give me a ride as well as some money. As a result, I kept him as my boyfriend. I soon noticed that he was getting leaner and leaner. Not long after this, he died. About six months after his death, I fell ill too, and returned to my hometown. I recovered and came back to Ibadan. But after three months, I broke down and was taken to UCH from where I was referred to this NGO for care*".<sup>34</sup> Although this review did not measure poverty rate in the studied community, because poverty is a relative concept and it is difficult to measure to be able to generate uncontroversial and valid arguments, yet there are indications of household poverty in the communities. Most of the households (62.4%) lack good nutritional culture, and they are not accessible to basic needs of life. Due to this household poverty, many people ignored basic health needs.

#### **Poverty and HIV/AIDS are interrelated**

"Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of representation and freedom".<sup>35</sup> "Poverty's companions encourage the infection, undernourishment, lack of clean water, sanitation, and hygienic living conditions. Others include high incidence of opportunistic infections, like genital infections, and tuberculosis. Inadequate public health services; illiteracy and ignorance encourage high-risk behaviors, from labour migration to alcohol abuse and gender violence. Poor leadership response to either HIV/AIDS or the problems of the poor; and lack of confidence or hope for the future further compound the state of the affected people."<sup>36</sup>

#### **Urbanization and HIV/AIDS**

Cities in the study area have many social institutions, which engage in different activities capable of spreading HIV/AIDS. These social institutions include hotels, brothels,

and fast food joints, big market places attractive to many people of diverse cultural backgrounds, and big motor parks, which are transit parks. Activities within these social locations encourage illicit sexuality. Most of these places in the cities are hives of itinerant commercial sex workers. In the rural areas, there are limited numbers of such social institutions. However, that does not suggest that itinerant sexuality is not conducted in the rural communities. It only means that opportunity for HIV/AIDS infection is lower in the rural areas compared to the cities.<sup>37</sup> This suggests that unregulated culture contact from different cultural groups may promote HIV transmission. Due to poverty and women's unequal access to financial resources, many young women in higher institutions resort to sex as a means of accessing these resources. Thus, they are susceptible to HIV/AIDS infection. Another related problem associated with the educational system in Nigeria is the irregular calendar and frequent strikes by teachers and lecturers, which make their students, idle whenever they are on strikes. Since they are sexually active, many of the young women among the students become itinerant commercial sex workers in cities when their schools are closed.

#### **Conclusion**

In conclusion, cultural practices exist in different communities and take different forms, which have positive and/ or negative contribution to people's life. It is emphasized that differential power relations at the international, national, and micro-social levels of interaction propagate HIV/AIDS in Sub-Saharan Africa. HIV programs must address the root causes of gender-based vulnerability to HIV. HIV programs must focus on greater sensitization and education of men and women on the traditions and cultural practices that increase the risk of HIV infection. Governments should implement policies and legislation enacted against harmful traditional practices that increase vulnerability to HIV across the nation. Governments must take stronger measures to prevent the rising incidences of violence against women and sexual minorities. The introduction of sex education curriculum in schools, and boys and girls should be monitored and ensure compliance by various schools in the country and information gathered will affect HIV prevention. Outreach programs must involve the use of positive role models (male and female) in the media that break existing stereotypical images and beliefs of HIV. Opinion leaders and religious leaders must be engaged in behavior change interventions such as promoting condom use and total abstinence.

#### **Conflict of interest**

The authors indicated no conflict of interest.

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