



Socio-cultural Factors in the Access of Women to HIV/AIDS Prevention and Treatment Services in South-southern Nigeria

****Edlyne ANUGWOM¹, Kenechukwu ANUGWOM²***

1. *Dept. of Sociology/ Anthropology, University of Nigeria, Nsukka, Nigeria*
2. *Dept. of Social Work, University of Nigeria, Nsukka, Nigeria*

***Corresponding Author:** Email: akommiri@gmail.com

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Abstract

Background: The South-southern zone of Nigeria is one of the zones in the country that has reported consistent high prevalent rates of HIV/AIDS pandemic in the last decade. In spite of bio-medical reasons adduced for the spread of the pandemic, socio-cultural factors may be major issues in the access to both prevention and treatment services especially for women. Hence, this study investigated the socio-cultural factors, which influence the access of women to HIV/AIDS prevention and treatment services in Nigeria.

Methods: We utilized the social survey viz. the unstructured interviews and the focus group discussions (FGDs) as methods for collecting data.

Results: Socio-cultural norms, stereotypes and expectations still influence the access of women to these services. Such socio-cultural barriers are not significantly reduced by urbanization and the deadly threat of the epidemic. These socio-cultural variables, which impede the access of women to these services, are webbed around the dominant narratives of male superiority and the immorality culturally ascribed to women who openly discuss safe sex or seek prevention devices like the condom.

Conclusion: There is need for more emphasis on gender equality in sexuality and for HIV/AIDS programme planners and policy makers to think and act outside the box of the narratives of male superiority sponsored by socio-cultural norms in addressing the peculiar challenges of women in accessing HIV/AIDS services.

Keywords: Socio-cultural factors, HIV/AIDS, Prevention, Treatment, Nigeria

Introduction

There is no doubt that with an estimated 4.1% adult HIV/AIDS prevalence rate Nigeria still faces a great challenge from the disease (1). This is however, a remarkable decline from the over 5% prevalence rate in the early 2000s. A decrease made possible by a constellation of factors ranging from increased awareness, mobilizational efforts to huge financial and human resources targeted at the prevention to treatment continuum of the disease. It is only plausible to feel that the decline can be sustained in the context of unhindered access to both prevention and treatment

facilities especially by women who, all over Africa, have appeared more vulnerable to the disease. In Sub-Saharan Africa, women account for 58% of all HIV infections and the infection rate among young women ages 15–24 is approximately twice as high as those of young men of the same age bracket; this growing disparity is attributed to gender inequities which is now driving the epidemic in Sub-Saharan Africa (2). The vulnerability of women in this regard is largely tied mainly to the position and powers (lack of it) of women

in the prevalent socio-cultural norms of African societies.

The concern with socio-cultural factors in the transmission and management of HIV/AIDS is not novel since the major constraint upon behaviour modification which the epidemic demands of the population, has been weakened by socio-cultural factors impacting on behaviour and more crucially in the case of women, make people vulnerable to the disease (3). In the views of Loforte access to sexual and reproductive health services in Africa is conditioned by gender inequality, stigma and discrimination in a context of high HIV/AIDS prevalence (4). In sum, she contends in this insightful piece that women experience severe difficulties in gaining access to services and to adequate medical and preventive care for HIV/AIDS.

But beyond this predisposing character, socio-cultural factors may be equally crucial in both the decision to seek treatment and how such a decision is effected or implemented by women. This thinking emanates largely from the patriarchal nature of the typical Nigerian society which does not just limit women's aspirations but more fundamentally defines opportunities, roles and behaviour from a patriarchal dimension (5). Also germane in considering the impact of socio-cultural factors on access is a realization that beliefs, myths and socially conditioned perspectives influence the response of people especially the youths to HIV/AIDS in Nigeria (6).

The fact remains that in rural and more recently urban African societies, pathologies (severe illnesses) like HIV/AIDS and other afflictions have been explained by the populace by recourse to black magic and the occult (7-9). In such a situation the perception of illness and the approach to seeking a cure are determined or at least affected by this belief bred by socio-cultural reality.

An interesting revelation in the literature is that the cultural norms of the people make women vulnerable to infection and equally reduce their access to both treatment and prevention services (2, 3, 10-12). In fact, the publication by CRC which is an outcome of an extensive study on socio-cultural factors responsible for the spread

of the disease among women in Akwa Ibom state presents very penetrating insights into the nexus between cultural norms and the spread of the disease in Nigeria. In addition to identifying cultural factors like multiple sex partners, traditional health practices and rituals, partner exchange, wife inheritance, exchange of fluids during rituals and some ceremonies, extramarital sex which is allowed by culture etc. the study also uncovered bastions of ignorance, myths and half-truths as well as patriarchy which make women especially vulnerable to HIV/AIDS infection not only in the state but across the nation.

The present study tried to ascertain how access to HIV/AIDS prevention and treatment services are impacted on by socio-cultural factors especially gender and more crucially how such access is perceived by young women and girls in Akwa Ibom and Cross River states in the South-south geo-political zone of Nigeria. The main purpose therefore is to ascertain how women perceive their access to prevention and treatment as well as how the access to such services are mediated by gender considerations especially those bearing on socio-cultural norms of the people of the states. This is especially critical in the face of the generally acknowledged fact that the HIV/AIDS epidemic has a woman's face. In order to achieve the above aim the research adopted a participatory approach aimed at viewing issues from the eyes of those involved and also allowing them generate consensual solutions to perceived problems. Hence, the research used a combination of the focus group discussion and the unstructured interviews.

This study is limited in scope to Uyo the capital of Akwa Ibom state and Calabar, the capital of Cross River state which are in reality equally the epicentres of the HIV/AIDS response in these states. Even though these capital cities are not representative of the rural enclaves, they are still best locations for an inquiry into barriers to access and rights of women which would have been a highly misplaced and self-fulfilling endeavour in typical rural areas known bastions of patriarchy. In other words, the focus on urban areas gives one the opportunity to see the extent to

which socio-cultural factors hold sway in populations that are ideally more empowered than those in typical rural enclaves.

Methods

The study which was conducted in 2011 adopted the qualitative research method in order to achieve its objectives. Therefore it made use of a combination of the FGD and the unstructured interviews. In all, a total of six FGD sessions (three per state) were conducted with eight discussants in each session. The three sessions per state were made up of: female and male out of school youths (MOSY, FOSY); female sex workers (FSW); and representatives of faith based organizations (FBOs); public sector health service providers; NGOs; women and girls accessing treatment; women and girls infected but not accessing treatment; and people drawn from support groups; private sector service providers; and male and female members of the general population. In order to add more support to the FGDs, interviews were conducted with target respondents made up of the following people: support group members, public/private health providers, FSW, FOSY, MOSY and FBOs. The information collected from the above sources were analysed using purely qualitative approach in which key issues/questions of the research were teased out focusing on consensus and insights gathered from the field.

Results

Socio-Cultural Factors in Accessing Prevention Services

Adequacy of Information on HIV/AIDS Prevention

The participants in the FGD sessions in both states arrived at the consensus that although there is appreciable information on HIV/AIDS, the information is still considerably inadequate. They viewed inadequacy in this context in terms of the geographical reach of prevention messages and real awareness created from such messages.

Hence, the respondents were of the view that information is concentrated in the capital cities, Calabar and Uyo and other major urban cities like Oron, Ogoja and Eket. As a result, a large number of people living in other areas especially the rural enclaves are largely improperly informed (misinformed) and unaware of the basic nature of the disease. Clearly representative of the above views is the sentiments of one of the respondents, a male out of school youth (MOSY) who contended, “in as much as these messages exist there is not enough information yet, so more education should be given to people to properly orient them”.

In corroboration, another respondent argued that AIDS is not only real but deadly however there are still some people out there who it would appear are not totally convinced. In her own words, “if you advise such people to use condom or be faithful to their partners, they will not accept”. Therefore, the picture one gets from the above is that information on HIV/AIDS prevention is still not adequate in both states. Interestingly, these sentiments were equally reaffirmed in the face-to-face interviews where an overwhelming majority of the respondents were of the view that there is gross information disparity between the urban and rural communities in both states.

Access to Education, Knowledge and Prevention Tools

In the opinion of the FGD participants education and knowledge on HIV/AIDS is still low in both states even though a good number of people have some access to education and knowledge on HIV/AIDS. Hence, you have a situation where while some people are aware that HIV/AIDS is acquired through unsafe or unprotected sex some others do not believe that it is linked to sex. Thus, ‘when I was in secondary school in Eket, people came to talk to us about HIV/AIDS and how it is transmitted, they said it is because of sex but some senior students later told us not to believe them as there is no relationship between AIDS and sex. I did not believe them but I know some people did’ (female out of school youth (FOSY) respondent).

Also, girls and women can neither ask their boyfriends and husbands to use condoms nor are they expected to carry condoms like some men do. In fact, women who go against this are seen as promiscuous and as prostitutes. A situation vividly captured thus, 'the problem is that you cannot even suggest the use of that thing to your boyfriend. It's like if you say it you are accusing him of sleeping around or that you are not sure of yourself. No matter which one, it can end the relationship and give you a bad name. You know men talk to each other and even boast of their affairs' (Monica, 28 years old marketing executive). To confirm this cultural barrier to access to prevention tools, only one female respondent¹ out of the whole that took part in the FGDs has ever gone to buy a condom for her boyfriend, while all the other female respondents were of the view that they would not like their parents and spouses to see them with condoms. A tendency made unavoidable in view of the opinions of a lot of the men interviewed on the issue.

In fact, very illustrative of this view among the men is, 'for me any girl who goes to buy that thing is simple and short, a prostitute. Any woman, including my wife who tells her husband about it or gets it for them to use needs to be questioned. In short, she should be seriously sanctioned' (Etim, 42 years old father of 3).

Sources of Information and Education on HIV/AIDS

It was interesting to observe that while some of the respondents were of the view that women and girls share information and views on HIV prevention with men and boys; others disagreed arguing that gender inequality precludes this sharing of information especially for women who culturally would not be expected to either initiate or participate actively in such discussions. In spite of this sharp division, the respondents were of the opinion that women and girls receive information and education for preventing HIV/AIDS from the following sources: seminars by NGOs/faith-

based organizations (FBOs), workshops, information, education and communication (IEC) materials (posters, handbills, illustrated or pictorial documents), awareness workshops especially by international organizations and agencies, television, radio, and newspapers and magazines.

However, the respondents also believe that education on HIV/AIDS is still very inadequate and a good number of people are yet to change their sexual behaviour and orientation as such. In view of the above, they were of the opinion that school teachers should put more effort into integrating HIV education into normal school curriculum. Actually, one of the discussants, an FBO representative stated that there is a new initiative now being tried out in some schools in Cross River State. The respondents observed that a disproportionate percentage of the HIV/AIDS messages in both states are in English and it was only recently that efforts have been made towards changing this trend. As a result, in some communities and villages in Akwa Ibom state the acronym AIDS has been translated as '*itiata*' in the local dialect. While the foregoing opinions emanated from the FGDs, the interviews revealed that the girls and women are generally shy of accessing prevention or protection materials like condoms because of cultural expectations which do not allow women to buy them for their men to use.

Socio-Cultural Factors in Accessing Treatment

Gender and Access to HIV/AIDS Treatment

In recognition of the fact that access to HIV treatment is of acute importance in winning the war against the disease in Africa, this section tried to ascertain the critical socio-cultural and gender related factors which influence access to treatment. While there is a marked discrimination against women's access to prevention tools, the picture looks different in terms of treatment. Hence, it was the consensus of the group that more women and girls receive ART and treatment for AIDS related illnesses in public health institutions than men in both states. However, this is not borne out of a different set of cultural

¹ The lady in question happens to be a female sex worker (FSW)

referents but rather because women go for ante-natal clinics and more often than not they are made to be screened for the virus as is the regular policy in all public health institutions in these states.

Equally revealing is that the women are not as shy or shameful as the men. According to one of the participants, 'women have no shame to get tested and look for remedies if they are positive unlike the men who generally refuse to be tested' (Mary, 33 years old mother of two). However, service providers who were in the FGD sessions in both Uyo and Calabar were of the opinion that the ratio of women to men accessing treatment has not changed for over three year now; and that even though more women access treatment in the clinics, the difference is not very significant. But this fact was not however confirmed by the other FGD participants who claimed that even though they were not conversant with the statistics they still see that more women come for treatment than men.

Gender Related Problems Affecting Access to ART

In addition to the foregoing, the respondents identified some major problems faced by female patients in accessing ART in both states. A key problem identified is the poor financial situation of the women and girls which may make them not to go for treatment regularly especially when treatment sites or clinics are far from where they reside. Also, the respondents stated that there are some cultural issues that create problems for the women in accessing treatment. Hence, they pointed out that most times if a woman is positive the family and others would be against her believing that she is a prostitute. The family also tries to avoid stigma and believe that such a woman would give a bad name to the family. As a result, they make her an outcast and deny her the critical support to face the challenge of the virus. In fact, one of the respondents, a leader of a support group in Uyo narrated the story of a woman whose rich husband died of the virus and she was not allowed access to the husband's wealth by the family in order to take care of her-

self. Instead of this, the family ostracised her and without care her condition deteriorated and she passed on.

Also mentioned as influential in the lack of access to treatment were religious beliefs and self-stigmatization. Some infected persons believe in the ability of the pastor or man of God to cure them and thus shun treatment. Incidentally, some religious leaders encourage this attitude by claiming power over all illnesses as well as having the key to life and death. However, the respondents equally saw the declining confidence in ART as having negative impact on the decision to seek treatment. A few of the respondents reported cases of those on HIV/AIDS treatment that still developed opportunistic infections (OIs).

Gender Issues in Testing for HIV/AIDS

In spite of the existing regulation that requires compulsory testing for women on ante-natal visits in public health institutions, the respondents in the FGD sessions were still of the consensus opinion that women and girls are not pressured into testing for the virus in both states. The respondents rather saw what occurs as VCCT especially when women come for antenatal clinics. During such visits women are advised about the need for the HIV screening but they are not forced or compelled to test. In the words of one of the participants, a public service provider with the University of Uyo Teaching Hospital, 'our facility does not force pregnant women to go for test except when we have repeated cases of a HIV related ailment like diarrhoea, fever, severe sweating and even vomiting, we can then advise the patient to go for screening'. She went on to state that such screening or testing is preceded by counselling.

Peculiar Female – Friendly Services at Treatment Clinics

The participants in the FGD sessions were of the view that to make the clinics provide a female – friendly service, a good relationship between the health workers and clients should be established. This could be achieved through giving the clients enough counselling to open up to the health

workers; training more women as counsellors since they can easily understand the problems of fellow women. Actually a radical view of the way of establishing this friendliness was introduced by one of the support group members in one of the FGD sessions in Calabar when she argued that only those who are positive should be in charge of clinics offering treatment. On further probe, she argued that she based her suggestion on the observed nonchalance with which health service providers often approach the plight of the positive people. However, other participants did not see this as tenable.

Discussion

As evident from the discussion thus far, the respondents were of the view that the cultural norms of the people engender discrimination against women who are living positively (HIV/AIDS positive). The FGD participants pointed out that this discrimination is also evident even in death. Thus, even if a man is suspected of having died of AIDS the people will still go ahead to bury him properly with full rites but if it is a woman, the body is quickly interred without any elaborate funeral rites. Thus, it seems like the people simply cannot wait to bury the woman and her dreaded affliction.

The interactions during the fieldwork reveal that the respondents were of the view that socio-cultural barriers to access can be overcome through such measures as: giving girls and women more education on the use of condoms; encouraging church/religious leaders to take a more informed and evidence-based stance on the disease; female condom should be made readily available to women at all levels (the respondents argued passionately for this stating that the female condom is not yet common and is relatively expensive); the translation of prevention messages into local dialects in order to reach rural dwellers and less educated people; messages should also focus on treatment options as well as address the peculiar situation of women; male members of the population should be sensitized to recognise and re-

spect the rights of women to sexuality as well as encourage and respect the rights of their wives, girlfriends and sisters to freely make a choice. This is especially critical in view of the recognition that HIV/AIDS programs can help address women's access to prevention and treatment by addressing harmful gender norms and stereotypes (7) which treat women virtually as second class citizens especially in Africa.

Conclusion

There is need for more emphasis on gender equality in sexuality and for HIV/AIDS programme planners and policy makers to think and act outside the box of the narratives of male superiority sponsored by socio-cultural norms in addressing the peculiar challenges of women in accessing HIV/AIDS services.

Ethical Considerations

Ethical issues (Including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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The authors declare that there is no conflict of interests.

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