

# **HIV/AIDS OR NOT:**

## **SOMETHING MUST KILL MAN: OBSTACLES TO BEHAVIOUR CHANGE IN THE FACE OF HIV/AIDS INFECTIONS IN NIGERIA**

### **INTRODUCTION**

Following the detection of the first HIV/AIDS in Nigeria, a number of programmes were undertaken to create awareness of the disease and to generate behaviour change among the population. However, the expected behaviour changes have not occurred.

Socialization process, disbelief of the presence of HIV/AIDS in Nigeria, stigmatization / social rejection, and claims of invincibility anchored on divine protection and / or “Cure all” herbal remedies are some of the barriers.

This project was designed to assess the prevalence of these attitudinal barriers in a countrywide survey. The survey was conducted between November 2000 and January 2001 in six local government areas. Each location represented a geopolitical region.

These were:

**North Central:** Niger State, Kontagora Local Government

**North East:** Gombe State, Gombe Local Government

**North West:** Sokoto State, Sokoto South Local Government

**South West:** Oyo State, Ibadan South-West Local Government

**South East:** Abia State, Aba North Local Government

**South South:** Akwa Ibom State, Eket Local Government

In each location, interviews and Focus Group Discussions were held in selected areas of the cities where there were high concentrations of people, hotels and bars that provide venues for sexual networking. The target was the lower-middle classes and the masses given that they are the most vulnerable groups. Our sample was to interview **200** people, both male and female, in each location. In Ibadan (**South-West Region**) there were **205** respondents, as against **198** in Kontagora (**North Central Region**). Two focus group discussions were held per location.

This report has two sections

- Baseline information on HIV/AIDS in Nigeria
- Analysis of society’s attitude to HIV/AIDS in Nigeria.

### **BASELINE INFORMATION ON HIV/AIDS IN NIGERIA**

There is documented evidence that about 90% of Nigerians are aware of the causes and means of transmission of HIV/AIDS (*Caldwell et al, 1992*).

About the same percentage know the preventive measures and an increasing proportion of people have seen the destructive consequences of HIV/AIDS in their communities, yet this has not resulted in significant behaviour change.

A sex worker from a neighbouring West African country was the first HIV-Positive person in Nigeria in 1986. This discovery led to an erroneous belief among the general population and, to a large extent government officials that the disease was foreign and could not affect the Nigerians. Subsequent developments, particularly between 1995 and 2000, have proved that the assumption was wrong. By the end of the first quarter of 2001, data released by relevant agencies – National HIV/AIDS and STDs Control Programme

(NASCP); UNAIDS etc. indicate that 5.4% of the estimated 120 Million Nigerians are HIV-Positive.

When AIDS was first reported in Nigeria, there were denials and under-reactions to the epidemic. The denial was so widespread and so deep that relatives would not even allow diagnosis of AIDS to appear on the death certificate of their loved ones. Despite the denials among the general population, the then Minister of Health, **Professor Olikoye Ransome-Kuti**, was quick to accept that there was a problem. Thus, he developed a comprehensive AIDS programme, which was managed by an experienced person and Government and Non-Governmental Organizations support was received at the initial stage of the programme. AIDS prevention and control committees were set up at the state and local government council levels. All levels of government were directed to make statutory budgetary allocations for the control of HIV, AIDS and STDs. This was annually deductible from the federation account.

By about 1994, government support for the AIDS programme had waned and the International Organizations withdrew their support as result of international isolation of the Abacha regime. As a result, the National AIDS Program suffered a major setback coupled with the lack of support from government. Nigeria has now passed the stage of denial and government attitude to the epidemic has seemingly changed.

In December 1998, 12 years after the first AIDS case was reported, the first National Conference on HIV/AIDS and STDs Control and Prevention took place in Nigeria. The main objectives of the conference were:

- To provide advocacy at the highest level for HIV/AIDS and STDs Prevention and Control.
- To advocate co-operation, collaboration and support from all agencies and bodies for successful Petroleum Trust Fund (**PTF**) assisted HIV/AIDS Prevention and Control Programs.
- To develop an articulate plan of action towards effective HIV/AIDS Prevention and Control throughout the country.
- To create a forum for exchange of experience by involved persons.
- To streamline HIV/AIDS interventions in Nigeria.
- To review and update the National Policy on HIV/AIDS in Nigeria.

These objectives about AIDS and possibly sales of condom have increased significantly especially since the death of the famous Nigerian Afro beat Musician, **Fela Anikulapo-Kuti**, in August 1997.

The earlier disbelief and myth surrounding the disease have gradually disappeared. The national level of awareness is now estimated at above 75% in Nigeria. Despite the acceptance that AIDS is real in Nigeria, there has been resistance to social and behaviour change messages from the mass media. People continue to engage in risky sexual behaviour that was a way of life before the epidemic began.

### **SOCIETY'S ATTITUDE TO HIV/AIDS IN NIGERIA**

In a nutshell, Nigerian society's attitude is something that says "***Some people are destined to be infected***".

Thus, others continue with risky sexual behaviour, without worrying about the spread of **HIV/AIDS**. A delta of attitudinal dispositions combines to frustrate current **IEC** methodologies. These attitudinal dispositions revolve around:

- Sheer disbelief – a lot of people still feel that **HIV/AIDS** is far from their neighbourhood
- Gender biased socialization practices that favour men
- Social rejection / stigmatization of **HIV** infected persons
- Religious / superstitious beliefs

The tables below illustrate the attitudinal disposition of the Nigerian society to **HIV/AIDS**.

**Table 1: Responses to Questions of Disbelief (Percentage Distribution)**

| S/N | Questions                             | Eket<br>N=201 | Aba<br>N=203 | Ibadan<br>N=205 | Gombe<br>N=200 | Sokoto<br>N=199 | Kontagora<br>N=198 | X%    |
|-----|---------------------------------------|---------------|--------------|-----------------|----------------|-----------------|--------------------|-------|
| 1   | Ever heard of AIDS                    | 81            | 79           | 82              | 79             | 78              | 80                 |       |
| 2   | At risk of HIV infection              | 64            | 62.7         | 63.3            | 61.4           | 66.2            | 63                 | 63.4  |
| 3   | AIDS is disease of the rich           | 69.2          | 61.5         | 60              | 64             | 61.1            | 58.4               | 62.36 |
| 4   | There is no AIDS in my community      | 31.8          | 28.9         | 25.9            | 48             | 52              | 51.8               | 39.7  |
| 5   | Death from AIDS is just another death | 43.3          | 47           | 57.8            | 58             | 61              | 57.5               | 54.1  |

### **FINDINGS AND DISCUSSIONS**

Disbelief as barrier to positive behaviour change in the face of **HIV/AIDS** is not for lack of awareness. Our findings, in consonance with earlier findings reveal that about 79.8% of the population are aware of **AIDS**. The persistence of the problem of disbelief can be explained from two perspectives:

- Cultural
- Socio-economic

Among diverse cultures in Nigeria, there is a common belief that life here on earth is not eternal. Sooner or later, the inevitable phenomenon called **death** will come upon man who is only a sojourner on earth. It is a traditional belief that when people die, they have left the world (*a market place*) for heaven (*home*), and that they have finished their assignment and returned to whence they came. It is also a general belief that it is not necessary to start tracing the causes of death, when and how one dies should not be of significance to anybody.

This cultural view is expressed in many ways. For example, a -16 - year old sex worker in Aba focus group once declared “all die be die” when he was asked why she was in commercial sex in spite of her knowledge of **HIV/AIDS**. This statement translates to “every death is death”, implying that each person is going to die and that the causes of death does not really matter much. In **Gombe**, a similar response was obtained from a young man. He said:

*“HIV/AIDS or not, something must kill man”.*

This goes to underscore the observed high percentage of 63.4% in the sample that don't consider themselves at risk of **HIV/AIDS** infection. Thus, change from risky sexual behaviour is not part of their immediate agenda.

The 62.36% in support of the opinion that "*AIDS is a disease of the rich*" lends credence to the socio-economic explanation. A number of people still view **HIV/AIDS** in relation to socio-economic status. Thus, they believe that those in the lower class are saved from the **HIV/AIDS** scourge. The obvious, however, is that the population in the lower socio-economic group are the most adversely affected. Illiteracy, poverty, poor access to health care, poor access to mass media information etc. combine to aggravate the impact of **HIV/AIDS** among the subgroup.

This dimension is further extended in the belief that **HIV/AIDS** is not and cannot be in the low-income communities. As shocking as the assumption sounds, it has high-risk implications. For example, 39.7% of our sample engaged in high risk sexual activities on this basis.

Another attitudinal issue addressed by this project was socialization practices. Questions were asked to test the level of support of certain assertions as well as their implications for reproductive health / behaviour change. The socialization process in Nigeria is dichotomous for male and female. Males are socialized to "*act tough*" and perceive themselves as invulnerable to sickness, mistakes etc. They enjoy a number of privileges. It is common for a man to remind his audience that he is "*a man*". This assertion normally means to draw people's attention to his rights that might be under threat at such times. One of such rights is unlimited, culturally protected, sexual freedom that gives a man sexual right over many women.

**Table 2: Responses to Questions on Social Ideals for Male & Female (%Distribution)**

| S/N | Questions                      | Eket<br>N=201 | Aba<br>N=203 | Ibadan<br>N=205 | Gombe<br>N=200 | Sokoto<br>N=199 | Kontagora<br>N=198 | X%    |
|-----|--------------------------------|---------------|--------------|-----------------|----------------|-----------------|--------------------|-------|
| 1   | A real man cannot be sick      | 46            | 41.6         | 51.2            | 44.3           | 40.8            | 39.7               | 43.9  |
| 2   | Men cannot do without sex      | 96.4          | 91.3         | 94              | 95             | 96              | 90.8               | 93.9  |
| 3   | AIDS cannot infect healthy men | 52            | 58.1         | 53.6            | 58.5           | 60.0            | 59.2               | 56.9  |
| 4   | AIDS is a Woman's problem      | 34.8          | 30.3         | 28.0            | 27.8           | 26.2            | 22.0               | 28.2  |
| 5   | Decent people don't use condom | 49.1          | 50           | 47              | 53             | 61              | 57                 | 52.85 |

Unquestionable liberty to have sex and with many partners is a male social code across ethnic groups in Nigeria. It is generally believed that sexual urge in men is a biological necessity which cannot and must not be suppressed. This was confirmed by 93.9% of those surveyed. Most people hold the opinion that good health precludes sickness even when they engage in risking sexual behaviour, which threatens their very health. 56.9% of the respondents were under this opinion.

The "*real man*" concept was explained by a 23-year old secondary school teacher in Ibadan as:

..... a man who is well developed biologically, intellectually and economically. He knows his right. He knows when to meet a woman and when not to...

Another respondent, a female hotel staff in Kontagora described a real man as:  
... one who is mature, he can handle his private life well.

The implication of these assertions is that the real man is at liberty to decide when to apply caution, especially in his sexual activities. This liberty is usually abused in most cases with risky sexual behaviour. 43.9% agreed that the real man cannot be infected by **HIV/AIDS**, hence, they can engage in high risk sexual behaviour.

On the other hand, females are socialized to co-operate with men thus denying them basic decision making powers. This constraints their ability to say “no” to unsafe sex in most instances. Similarly, socialization practices promoted by ethical views held commonly in schools, churches and mosques and supported by the media is that “*decent boys and girls*” do not need condom. In simple terms, the idea suggests that only indecent people have the need for condom. They are perceived to be sex workers, wayward or immoral. At this backdrop are responses like “*I’m not like that*”, “*I’m safe*”, “*You think ‘am a prostitute?’*”, “*Don’t you trust me?’ etc.*

In our sample, 52.85% reasoned that decent people do not have to use condom.

In response to the question “*AIDS is a women’s problem*”, 28.2% mostly men believed it is. This belief has grave implications for sexual behaviour. For example, it implies that it is only women who should worry about the disease while men can continue risky sexual behaviour with business as usual attitude.

Stigmatization and social rejection of sero-positive people have led to denials of **HIV/AIDS** status by victims. The literature is replete with statistics on stigmatization of people living with **HIV/AIDS** by relatives, communities and health workers. (K. Awusabo-Asare, 2000). As high as 78.3% of the respondents say they would not disclose their status should they be confirmed seropositive. 36% say they would be shocked if they are tested positive. While 12.3% say they would be afraid, 22.8% reported they would be indifferent about it and that they would continue with their normal life.

When asked how they would feel if a relative is confirmed seropositive, 68.3% said they would be angry. 53% reported they would stop seeing the victim. 29.1% reported they would sympathize with the victim, while only 8.2% said they would be prepared to care for the victims.

The social attitude of neglect and abandonment of people living with **HIV/AIDS** has constrained victims to resort to escapist behaviour instead of openly seeking help. For example, a woman who operates a “*short rest*” hotel at Idioroko, a boarder town with Benin Republic in Ogun State, western Nigeria, with a high concentration of smugglers, armed bandits and sex workers sought help anonymously for fear of stigmatization. She called an early morning radio program – “*Fact File*” – broadcast by a private **FM** Station in Lagos – Ray Power. She told listeners that she was ‘shocked’ to discover that her husband and herself were **HIV-Positive**. After trading accusations, the husband abandoned her and the children, which necessitated her appeal for public support. She, however, refused to reveal her identity apart from giving contacts to which assistance can be forwarded.

The guerilla approach adopted by most infected persons in Nigeria not only pose challenges to **HIV/AIDS** control, it also hinders proper assessment of behaviour change methods in use.

The popularity and massive subscription to Christian and Islamic doctrines on faith / divine health and healing tend to exacerbate behaviour change crisis. These religious doctrinal teachings apparently fuses medical issues and spiritual matters. 74% of respondents reported they would consult their Pastors / Imams first should they have symptoms of **HIV/AIDS**. 65% said they would visit hospital after completing prescribed religious exercises including attending miracle crusades.

In southern Nigeria where Christianity is the dominant religion, simple faith statements received fabulous support. For instance, the following statements had echoed repeatedly:

*“God cannot allow AIDS to infect me” – 48.2%*

*“I’m covered with the blood of Jesus, AIDS cannot catch me – 41%*

In the Muslim North, the following statements replaced the above:

*“Death by AIDS is the will of Allah” – 52%*

*“Allah, the merciful protects me against AIDS” – 49.7%*

In addition to the assumed protection of the omnipotent, herbal medical practitioners compound the situation and further frustrates resistance to behaviour change instruments. Their cliché that God has “*opened their eyes*” to curative elements in herbs which they have, under divine guidance compounded, is a perfect remedy to all known diseases are usually displayed on television. These “*cure all*” alternative herbal remedies readily promises users immediate cure and prevention thereby creating resistance to behaviour change instruments. 18.2% believed these remedies can cure **HIV/AIDS** and therefore have no need to be afraid of **AIDS**.

### **GENERAL COMMENTS**

The study reveals that denials about the presence of **HIV/AIDS** in Nigeria have diminished. However, a number of attitudinal barriers have hampered significant change in behaviour. A combination of disbelief, stigmatization, herbal remedies have forced victims to resort to vindictive clandestine behavioural approaches. Various communities in Nigeria occasionally wake up to face a passing shock when news media reports present new **HIV/AIDS** infections. The following cases are examples:

- *Oil rich Niger Delta belt in South Southern Nigeria was recently shocked by news media reports that HIV infected female sex workers now lure unsuspecting men, mostly drivers and young professionals, to hideouts where they are forced at a gun point to engaged in sexual ordeals. After such episodes, they would happily announce to their victim that all of them are **HIV/AIDS** carriers and that he’s just been ‘infected with the virus’. At the time of report, 18 men had been infected in Port Harcourt, Owerri and Warri. The Commissioners of Police in the affected states – Rivers, Delta and Imo advised the victims to report at the Police Stations for proper investigations.*
- *In Gombe, a young man in his midlife few months ago told his story to newsmen. He revealed that over a period of one month he checked into a hotel in a suburb of the*

*state capital where he purposely seduced and infected sixteen school girls with HIV/AIDS.*

These attitudinal blocks prevalent in the general society as well as clandestine vendetta by **HIV/AIDS** carriers calls for urgent IEC instruments to check rapid spread of **HIV/AIDS** in Nigeria..

*For more information contact:*

**Principal Manager - Research & Projects**

**Multi-Sector (Projects) Limited**

***(Development Policy Konsult)***

Road B, Plot 2, Opposite Police Station

Oluyole Estate

G.P.O. Box 31288, Dugbe, Ibadan, Nigeria.

Tel/Fax: 234 – 2 – 2319486

Email: [multisec-nigeria@skannet.com](mailto:multisec-nigeria@skannet.com) ; [multisec\\_dev@yahoo.com](mailto:multisec_dev@yahoo.com)

Internet: <http://nav.to/multisec>