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SOCIO-CULTURAL FACTORS INFLUENCING EARLY DIAGNOSIS AND PREVENTION OF HIV AMONG WOMEN OF REPRODUCTIVE AGE IN SOUTHWESTERN NIGERIA

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ABSTRACT

INTRODUCTION

Culture and social status are key determinate of attitude and behaviour towards prevention and control of many diseases of Public health importance including HIV.

OBJECTIVES

This study determines socio-cultural barriers to early diagnosis and prevention of HIV among women of reproductive age in Southwestern Nigeria

METHODS

Descriptive cross sectional qualitative study among women of reproductive age group and health care givers concerning socio and cultural factors influencing diagnosis and prevention of HIV. Five Focus Group Discussions (FGD) of 8 eligible respondents each were conducted using a pretested FGD guide in collecting data from the randomly selected subjects. Data was analyzed using simple content analysis.

RESULTS

Cultural and social factors influencing HIV vulnerability and transmission identified include low education status, poor awareness among women, low employment and economic power, adverse religious beliefs and practices, reluctance to accept teaching of FLHE in schools and the public, stigma and discrimination even from the health care workers affecting health seeking behaviour. Other factors include polygamy, male dominance, low decision power and value of women, remarrying after divorce, widowhood rights, wife inheritance and sharing, early marriage, and some cultural breastfeeding practices encouraging HIV transmission

CONCLUSION

Raising community awareness by traditional, cultural and religious gatekeepers becomes imperative to circumvent many of the identified social and cultural factors constituting barriers and influencing HIV diagnosis and prevention

KEY WORD

Socio-cultural factors, HIV, STIs, women of reproductive age

INTRODUCTION

The global HIV epidemic continues to expand, with an estimated five million people becoming infected each year.[1] In sub Saharan Africa, 61% of adults living with HIV are women.[2] As more women contract the virus, the number of children infected by their mothers has been growing[1]. HIV prevalence in Nigeria stabilizes at 4.1% going by national data in the last 2 years despite ongoing prevention efforts as well as treatments; care and support for People Living With HIV/AIDs (PLWHAs).[3] Governments have spent huge resources on prevention efforts. These include primary prevention (both population and high risk strategies), early diagnosis through opt out HIV screening, and treatment, care and support as secondary prevention efforts not leaving tertiary prevention behind. Over the years, little emphasis had been placed on cultural and socioeconomic context of HIV infection, an issue that continue to modify disease transmission and hence the HIV national response.

Culture determines social relations and gender roles, and has profound impact on the total life of members of a cultural group or community. Culture, traditions, social class and religion have influence on behaviour, attitude and practices of Nigerians[4]. Issues relating to sexuality and breastfeeding among others have implications for existing socialization and culture mix. These equally have roles to play in modifying the epidemiology and control of HIV among women.[5] The 2007 national guidelines which advocated exclusive breastfeeding for all HIV pregnant mothers provided AFASS criteria were met, may have likely undermine the universality of the culture of breastfeeding for all newborn most especially in the African sub region.[6] The education status of women, poverty, malnutrition, gender inequality, inability to negotiate sex, poor economic powers and social status are examples of ways in which women becomes vulnerable to HIV

Health seeking behaviour of women is a social issue with great gender peculiarity. Coupled with societal stigma and human rights violations associated with HIV infections, [7] a study to determine these socioeconomic and cultural factors is long overdue. These information would assist to modify both primary and secondary prevention efforts towards reduction in disease prevalence. This study determines socio-cultural barriers to early diagnosis and prevention of HIV among women of reproductive age in Southwestern Nigeria

METHODS

Study Area: Osogbo, the capital of Osun State in Southwestern Nigeria was the study area. It has a population of 3.5 million people according to the last national census.[8] Prevalence of HIV in Osogbo was a bit lower than the national average put at 4.1%. [3] Most HIV care work takes place at the secondary and tertiary care level while Primary health care centers are mainly for Counseling and Testing services. There is a teaching hospital and a general/state hospital in the town.

Study design: was a combined community and health facility based descriptive cross sectional qualitative study of socio-cultural factors influencing early diagnosis, management and prevention of HIV among women of reproductive age in Osogbo in Southwestern Nigeria

Study population: All women of reproductive age group15-49 years in the city constituted the reference population while those who took part in the study constituted the study population.

Sampling: One out of the two Local Government Areas in Osogbo was selected by simple random sampling employing simple balloting. From the ten wards in the local government, three were chosen at random. Eight eligible women per ward were conveniently selected to join their counterparts from other wards to make a total of 24 subjects. These were randomly divided into 3 FGD groups employing simple balloting

For the health care workers supporting the general and teaching hospital in the city, 4 female social workers and 4 female nurses (all working in HIV related units) in the state general hospital were selected to join same number of selected counterpart from the teaching hospital, making a total of 16. These health care workers were divided into two FGD groups using simple random sampling method.

Data collection: A total of five focus group discussions were held using a pre tested focus group discussion guide. Discussions were made in both English and vernacular to ensure good understanding of questions. The use of an independent observer was employed during the discussion to further guide this focus group discussion. Variables examined include social and cultural issues affecting HIV diagnosis and prevention in their communities.

Ethical clearance: to conduct the study were obtained from the Health Research Ethics Committee of Osun state university. Further permissions were obtained from local heads of communities. Written informed consent was obtained from each of the discussants.

Data management: Qualitative responses were analyzed using simple content analysis. in terms of nature and responses to questions as well as cogency and frequency of points raised in the various questions. An excel sheet was used to enter socio-demographic data of the discussants and resulting analyzed data was presented in form of a simple frequency table.

FGD RESULTS

In response to factors making women more vulnerable to HIV than men, all discussants agreed that women were more vulnerable. Reasons given include low educational status and low awareness among women (three quarter of discussants), women being a weaker sex (a quarter of respondents), low employment and economic power which make them succumb to sexual pressure from men for financial gains(about two thirds of respondents), cultural practice like polygamy and male dominance (half of respondents), low decision power in relationships and families(half of discussants) and religious beliefs(half of discussants)

Discussants believed that women have not been coming out for Voluntary Confidential Counselling and Testing because of fear of stigma and discrimination (all discussants), since HIV have no cure yet (a third of discussants), fear among married women that their husbands may send them parking out of their matrimonial homes if found HIV positive (three quarter of discussants), religious shame if found HIV positive (half of discussants) and association of HIV with promiscuity (half of discussants)

Sexual transmission has not reduced among women because of some socio-cultural practice such as polygamy(all discussants), wife inheritance and remarrying after death of husbands(half of discussants), early and forced marriage which predispose women earlier to sex and sexually transmitted infections (half of discussants) and religions forbidding mentioning sexual issues in public(another half)

Family Life Health Education (FLHE) has not been taught in schools and public places as proposed by governments because religions and cultures frowned at it as if it would teach students the confidence to be promiscuous. In addition, parents and some teachers kicked against it for the same religious and cultural beliefs.

On condom use, about half of discussants believed that our culture does not support condom use. Christianity generally does not support contraception (a third of discussants), while culture does not permit a woman negotiating condom use during sexual intercourse with her husband otherwise she is suspected of infidelity (half of respondents).

On culture and breastfeeding, all discussants agreed to the universality of breastfeeding and its cultural acceptability. Any condition that will prevent a woman from breastfeeding her child may give rise to suspicion of a HIV or other chronic disease (half of discussants). In addition, it may lead to friction between mother in-laws who would insist on breastfeeding her grandchild; and the woman who may have decided not to breastfeed for some reasons including health grounds (half of respondents). Half of respondents believe that affordability and safety may be an issue in exclusive replacement feeding. All said all religions preaches breastfeeding

Stigma and discrimination can reduce if women are well educated(half of discussants,) if they have good economic powers(half of discussants), if some cultural practices can be

abrogated(three quarter of respondents)m and if religions could be more flexible on contraception and raising sexual awareness and teaching FLHE in public and schools to young women (all discussants)

DISCUSSIONS

Culture is regarded as the resume of life of a community, a way of life among some people which guides their day to day living, norms and practices. The custodians of culture are the traditional and faith based institutions, they are gate keepers of attitude and behaviour are critical assets in the fight against HIV/AIDs.

Reasons give by discussants to affect women vulnerability to HIV supports other studies in which sexual violence and coercion, unequal access to education, economic options and legal protections was found to be major factors that increase women vulnerability to HIV.[9]

In some Nigerian cultures, men think that only women should be tested and treated for STIs. So eventually men would get STIs without it being reported or treated. The implication of this trend is that men could freely infect their wives and others in sexual relationship, thus increasing societal prevalence of STIs including HIV.

Culturally, a wife is not expected to refuse sexual advances and request from her husband even in the face of HIV threat. She may be accused of sexual infidelity and may be charged to be guilty of committing abominable sexual offence. By this, women are not able to negotiate safer sex, and this has implications for HIV transmission. Many men also believe that condoms should only be used in commercial text with prostitutes

Culture of patriarchy-men making all decisions, and women must be submissive- takes place in almost all cultures and communities as mentioned by discussants in this study. This supports another Nigerian study in which the current high prevalence of HIV and in women and low level of coverage of PMTCT was said to be largely due to the influence of cultural practice.[4]

Early marriage and child bearing as mentioned by discussants will expose women to earlier sexual activity and sexual risks including HIV. This is supported by another similar study.[10] Polygamy is still practiced in many cultures almost all over the world. If one of the women is sexually unfaithful, the probability is high that this cohort of sexual links within same family could transmit HIV among themselves. The Islamic religion for example openly support polygamy, and Muslim men may marry up to four wives at a time.

Among the Benue people in Nigeria, the cultural practice of wife sharing and wife hospitality would only contribute to the sexual woes of women as some close members of a wife are traditionally entitled to same women who are in a marriage relationship. Failure of women to adhere with such cultural practice, many believe would make her incur the wrath of the gods.

Among the Bahimas people (Nkore in Uganda), the father of a bridegroom have the right to test have gone by having the first sexual access to the new bride.[11] Also among the Bahimas, adultery is forbidden for women but men have the right to go outside for sexual pleasures

Widow inheritance is another cultural practice that increase sexual risk of women and which may affect her vulnerability. Others include marital instability or divorce in which the woman wants to re marry and have children for the new husband.[10]

Cases of sexual violence such as rape are common occurrences these days, [12] which also increase vulnerability of women to HIV and STIs. Since many of these cases were not reported, then testing for STIs including HIV, and subsequent treatment becomes an issue because the associated stigma and discrimination would affect her health seeking behaviour and many would not turn up to confess and treat the medical condition.

The low socioeconomic factors mentioned by respondents as reasons for vulnerability and social factors militating against testing, and treatments for HIV is a big determinant. These may include low education (and hence poor awareness), poverty (and hence poor affordability of contraceptives and STIs management), poor decision power that makes them to succumb to sexual pressure from men (due to potential economic gains) and lack of stable occupation and income. All these would affect prevention efforts against STIs. This supports another study in which those with a lower socioeconomic status were more likely than those with a higher socioeconomic status to be infected with HIV-1 (17% versus 4%), syphilis (66% versus 24%) and hepatitis B (52% versus 26%).[13] In another related study [14] higher socio economic status was associated with a more mobile lifestyle, later sexual debut and marriage among both sexes, and condom use among women aged 25-49

Discussants mentioned reluctance of the community towards raising sexual awareness and teaching of FLHE in schools, for religious and cultural reasons as possible reasons for changing epidemiology of HIV most especially among young women. This supports other studies in which mixed feelings characterized introduction of FLHE in secondary schools. [15,16]. Teaching and raising awareness would give women the right information in terms of STIs self prevention and what to do and where to go in case they need medical attention.

Stigma and discrimination for cultural and social reasons have prevented many women from accessing HIV care including testing, as supported by another study.[17-19] This is happening in Nigeria for example despite the existence of national policy against stigma and discrimination against PLWHAs. Discrimination has gone far in Nigeria to the extent that health care workers are involved, and the conflict in disclosure have affected prevention and treatment efforts for many PLWHAs as reported in a study.[7] Eventually the client goes for traditional and alternative treatments including religious and spiritual care which eventually may lead to delays in accessing orthodox medical care and prompt management of impending complications. This is supported by another study on use of alternative medical therapy among PLWHAs[20]

Discussants responses on cultural acceptability of breastfeeding may be so significant most especially as the 2007 national guidelines on PMTCT advocates options of infant feeding including exclusive replacement feeding (among PLWHAS). Thus the society becomes suspicious of a disease among women who choose not to breastfeeds, the mother in-laws who are not informed about disclosure (for fear of stigma) would insist on exclusive breastfeeding for cultural reasons. Eventually friction occurs between the woman and her mother in-law due to competing interests, and family breakage becomes imminent. Many women may eventually mix-feeds, an action that may facilitate MTCT. In a supportive study, choice of IFC depends on ability of women to make a choice during ANC and availability of an enabling environment to practice the selected methods of IFO.[6]

In addition, the social issue of affordability could constitute challenges to exclusive replacement feeding in an environment like ours where women have low socio economic powers. This social and cultural challenge had been resolved with the 2010 national guidelines advocating that all HIV positive women of reproductive age should be encouraged to exclusively breastfeeds under cover of Antiretroviral drugs (ARVs)

CONCLUSION

Several cultural and social influences affect the epidemiology of HIV/AIDs among women, including testing, management and prevention. As most of these issues bothers down on health education, the need to raise awareness among traditional, cultural and religious gatekeepers becomes imperative. It is also important to take all positive measures to improve social and economic status of women.

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Socio-demographic characteristics of focus group discussants

Variables(n=40)	Frequency	Percentage
Age in years		
21-30	19	47.5
31-40	13	32.5
41-50	8	20.0
Sex		
Female	28	70.0
Male	12	30.0
Religion		
Christianity	23	57.5
Islam	17	42.5
Traditional	0	0.0
Others	0	0.0
Highest level of education		
Primary/Secondary	6	15.0
Secondary	21	52.5
Tertiary	12	30.0
Post graduate	1	2.5
Others/none	0	
Marital status		
Married	25	62.5

Single	13	32.5
Separated	1	2.5
Widowed/divorced	1	2.5
Others	0	0.0

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