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CULTURAL FACTORS AND TRADITIONAL PRACTICES OF THE PEOPLE IN DELTA STATE ABOUT HIV/AIDS PANDEMIC

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ABSTRACT

This study examined the cultural factors and traditional practices of the people in Delta State of Nigeria about HIV/AIDS pandemic. The research design was a descriptive survey. To guide the study, three research questions were raised and answered and two research hypotheses were formulated at 0.05 level of significance. The population of the study consisted of all patients of general outpatient department of the government hospitals in south and north senatorial district of Delta state of Nigeria. The instrument was a questionnaire, the face and content validity were ascertained by some medical practitioners in the hospitals and experts in the field of counselling psychology. The Reliability of the instrument was determined, using the Cronbach Alpha and it yield the value of 0.86, ascertaining the internal consistency. The findings revealed that; there

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are prevailing attitude, beliefs and myths surrounding HIV/AIDS by the people in Delta south and north senatorial districts. The people are also conversant with voluntary counselling, testing and antiretroviral therapy. There are also both negative and positive impacts of socio-economic and educational background on HIV/AID respectively. It was therefore concluded that Cultural and traditional practices are prevalence in Delta state. These practices have positive impact on the educated patients and that the disease is been treated with less than honest approach by the populace in Delta state. This may spell doom for the community if not check. It was recommended that the DELSACA and NGOs (IPS) in Delta State should educate patients and the general public through electronic and mass media about HIV/AIDS among others.

INTRODUCTION

Human Immune Deficiency Virus (HIV) infection, is a worldwide phenomenon, it has constituted a serious problem in this present dispensation. The HIV epidemic has greatly affected health, social, and economic sectors in the developing world and is one of the main reasons for little progress in addressing maternal health and their male counterpart (Kitara, 2012). The First case of HIV was reported in Nigeria in 1986 since then HIV prevalence increased exponentially until it peaked at 5.8% in 2001. From ANC Survey Report 2010, it was deduced that HIV prevalence variation across states remain considerable, ranging from 1% to 12.7. The report also stated that the stabilizing of HIV prevalence is probably due to the massive scaling up of ART (Anti-Retroviral Therapy) services. ART services have resulted in improved quality of life and reduce mortality amongst people living with HIV.

However, Nigeria has an estimated of 3.4 Million people living with HIV, second only to that of South Africa (Wagbatasoma & Okojie, 2006). Approximately 54% of these individuals living with this virus are within the age range of 15 – 64 years, which cut across all levels of socio-economic and educational background of the people. In 2012, three hundred and eighty-eight thousand eight hundred and four (388,304) new HIV infections were reported with approximately two hundred and seventeen thousand, one hundred and forty-eight (217,148) AIDS related deaths in the same year. In this regard, Nigeria bears nearly 10% of the global burden of HIV/AIDS (Odimegwu, Akinyemi & Alabi 2017). Response to this crisis requires a massive, multi-sectarian, and coordinated global effort to sensitize the populace.

Also, Nwaorgu (2009) reported that, despite the havoc which HIV/AIDS has caused throughout the world, particularly in Africa, Nigerians have regrettably, continued to carry on as if the scourge of HIV infection is not a deadly one. The researcher regretfully noted that, those that were gainfully employed, unemployed, skilled and the unskilled maintain the same status quo towards the pandemic. They still maintain multiple sex partners and engage in casual and unprotected sex. Monjok, Smesny and Essien (2009) stated that over four million Nigerians have contacted AIDS virus

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probably because of the poor control strategy, poverty level educational background. Sadly, the problem has been compounded by the fact that the disease is still being treated with a less than honest approach by many Nigerians specifically in Delta State (Oduenyi, Ugwa, Ojukwu & Ajasigwe.2019). Perhaps the cultural factors and traditional practices of these Nigerians may have necessitated this approach towards the disease. The study of Iyamu and Alika (2011) revealed that, the cultural belief system plays little or no role, in the attitude of the educated and well-placed persons in the community. While, Kitara (2012) posited that ignorance, poverty, and high illiteracy level, have propel the increase of the disease. The researcher argued that in some cases cultural belief system has no effect on educated persons, perhaps because of their exposure. According to the ANC report (2010), on HIV/AIDS pandemic, HIV has a prevalence of 4.1% in Delta State. This implied that HIV is dominance in Delta State. There is the need therefore, for a massive multi-sectarian (health counselling, psychological and legal services) and coordinated global effort to stage awareness programmes to control the spread of the disease in Delta State. Majority of the people in Delta State, seem not to be aware of the dangers of this disease as the cultural factors and traditional practices of the people in Delta State are shrouded in great myths like:

1. You have to drink a bucket of infected saliva, before an individual can become infected with HIV/AIDS.
2. Sexual intercourse with a virgin can cure HIV. This has led to many rapes of young girls and children by HIV positive men who often infect their victim (Iyamu & Alika, 2011).
3. The disease only infects gays and of course it is the white man's disease.
4. HIV can pass through latex. (Babalola, 2007)

These cultural factors and traditional practices of the people in Delta State have led the researchers to examine the effects of these practices on the spread of HIV/AIDS in the state. The prevalence of HIV in Delta State according to the ANC Reports in 2010 is 4.1%. Statistics from the various hospitals under study shows an ascending increase of the disease within the state. If precautions are not taken, higher percentage of the populace in Delta state may be infected. This may spell doom for the society. It becomes necessary to examine the cultural factors and traditional practices of the people in Delta State on HIV/AIDS pandemic.

PURPOSE OF THE STUDY

This study examined the cultural factors and traditional practices about HIV/AIDS among the people in the two senatorial districts in Delta State. Specifically, it's investigated the prevailing attitude, beliefs and myths surrounding HIV/AIDS and their effects on the people in Delta south and north senatorial districts. It also investigated

how conversant are they with voluntary counselling, testing and antiretroviral therapy. The impacts of socio-economic and educational background on HIV/AID were also accessed. The essence of the study was to check the spread of the disease in Delta State, through massive awareness programme. To guide the study the following questions were raised and answered, in addition two hypotheses were formulated and tested at 0.05 level of significant.

1. What are the cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts?
2. Do cultural factors and traditional practices affect the attitude, beliefs and myths about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts?
3. Do patients know how to access voluntary counselling/testing and antiretroviral therapy?

HYPOTHESES

1. Cultural factors and traditional practices about HIV/AIDS do not significantly affect patients in public hospitals in Delta south and north senatorial districts based on educational qualification.
2. Cultural factors and traditional practices about HIV/AIDS do not significantly affect patients in public hospitals in Delta south and north senatorial Districts based on socio economic status.

METHODOLOGY

The study adopted a descriptive research design. This design involved gathering data mainly through questionnaire without manipulating the research variables in an attempt to get the views from the respondents. The population of the study was all patients in general outpatient department of the government hospitals in Delta south and north senatorial districts of Delta state. The hospitals were: Central Hospital Warri, General Hospital, Ekpan, Central Hospital Ughelli and Central Hospital Sapele.

The sample for the study was 350 patients. They were conveniently gathered from the four identified government hospitals in Delta south and central senatorial districts.100 patients were selected from the hospitals in Warri, Sapele and Ughelli; then 50 patients were gathered from Ekpan due to the small population there. All respondents were from outpatient-clinic and Anti-Retroviral Clinic (ART) of sampled hospitals.

The instrument for the research was a questionnaire. It was made up of two sections. Section A contains the demongraphic informations about the respondents. While section B, contains a well structured opened and closed ended items to elicit subjects opinions on the topic of study .

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The face and content validty of the instrument were assessed and ascertained by experts from medical sciences and counselling psychology Univesity of Benin in Nigeria. The researchers administered 30 copies of the questionnaires to the patients at the other departments in the sampled hospital. The Cronbach alpha reliability was used. It gave an acceptable reliability of 0.86. All the items were retained as each of them had a strong item-scale total greater than 0.30. The questionnaires were personally administered by the researchers who visited the various hospitals at different times. At each times the questionnaires were all collected from the respondents after completion. The data were analyzed using frequency and percentages for the research questions while Analysis of Variance (ANOVA) was used to test the hypotheses. The two hypotheses were tested at 0.05 significance level.

RESULTS

The results from the study are presented accordingly.

Research Question 1:

What are the cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts?

Table 1: Frequency of the respondents on cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts.

	Items	**Yes**	**No**
1	Have you heard of HIV/AIDS?	232(96.7%)	08(3.3%)
2	Do you know anyone living with HIV/AIDS?	144(60.3%)	95(39.7%)
3	Do you know how HIV/AIDS can be contacted	207(89.2%)	25(10.8%)
4	Have you ever engaged in risky activities	70(31.1%)	155(68.9%)
5	Do you use protection?	89(46.1%)	104(53.9%)
6	Do you know any risky sexual behaviour?	64(28.2%)	163(71.8%)
7	Do you know ways in which HIV cannot be contacted?	173(73.0%)	64(27.0%)
8	Do you know of any HIV myths (false stories)	201(90.5%)	21(9.5%)
	Ways HIV/AIDS can be contacted	**Frequency**	**Percentage**
1	Blood transfusion/contact	74	17.9
2	Unprotected sex/multiple sex partners	175	42.3
3	Unsterilized sharp objects	106	25.6
4	Breast feeding/ through mother to child	51	12.3
5	Kissing/hugging	06	1.4
6	Sharing of same toilet and bathroom	02	0.5
	Ways HIV/AIDS cannot be contacted	**Frequency**	**Percentage**
1	Eating together, living together	79	17.6
2	Sterilized objects	89	19.8
3	Hugging, handshakes, kissing, and bathing together	84	18.7

4	Blood screening and avoiding contact with blood	45	10.0
5	Using protection and having one sexual partner	111	24.7
6	Abstinence	27	6.0
7	Medical check up	07	1.6
8	Tattoo and tribal marks	06	1.3
9	Mosquito bite	01	0.2
	Myths about HIV/AIDS	**Frequency**	**Percentage**
1	HIV/AIDS shorten life	51	11.4
2	HIV/AIDS is punishment for sin	38	8.6
3	HIV/AIDS is treated traditionally	13	2.9
4	HIV/AIDS is from animals such as dog and monkey	38	8.6
5	HIV/AIDS is from witchcraft	13	2.9
6	HIV/AIDS is transferred spiritually and through body contact	152	34.2
7	HIV/AIDS is by kissing someone in a dream	63	14.2
8	No drug can cure HIV/AIDS	13	2.9
9	HIV/AIDS cannot marry	25	5.6
10	Government give HIV/AIDS patients injection to die	38	8.6

The result in Table 1 showed the responses on the cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts. It further showed that 232(96.7%) agreed that they have heard about HIV/AIDS, while 08(3.3%) disagreed. 144(60.3%) of the respondents agreed that they knew someone living with HIV/AIDS, while 95(39.7%) disagreed. 207(89.2%) of the respondents agreed that they knew how HIV/AIDS can be contacted, while 25(10.8%) disagreed. 70(31.1%) of the respondents agreed that they have engaged in risky sexual activities while 155(68.9%) disagreed. 89(46.1%) of the respondents agreed that they use protection and 155(68.9%) disagreed. 89(46.1%) of the respondents agreed that they knew risky behaviours, while 104(53.9%) disagreed. 173(73.0%) of the respondents agreed that they knew ways in which HIV cannot be contacted, while 64(27.0%) disagreed. 201(90.5%) of the respondents agreed that they know HIV myths (false stories) disagreed.

Table 1 also revealed the six (6) ways people contact HIV/AIDS as identified by the respondents. They are through: unprotected sex/multiple sex partners (42.5%), unsterilized sharp objects (25.6%), blood transfusion/contact (17.9%), breast feeding/ through mother to child (12.3%), kissing/hugging (1.4%) and through sharing of same toilet and bathroom (0.5%). Table 2 further showed the nine (9) various ways HIV/AIDS cannot be contacted as identified by the respondents. These includes: using protection and having one sexual partners (24.7%), using sterilized objects (19.8%), hugging, handshakes, kissing, and bathing together (18.7%), Eating and living together (17.6%), blood screening and avoiding contact with blood (10.0%), abstinence (6.0%), medical checkup (1.6%), tattoo and tribal marks (1.3%) and mosquito bite (0.2%)

Another revelation from table 1 was ten (10) myths (false stories) about HIV/AIDS as identified by the respondents. They are: HIV/AIDS is transferred spiritually and through body contact (34.2%), HIV/AIDS is by kissing someone in a dream (14.2%), HIV/AIDS shorten life (11.4%), HIV/AIDS is punishment for sin (8.6%), Government give HIV/AIDS patients injection to die (8.6%), HIV/AIDS is from animals such as dog and monkey (8.6%), HIV/AIDS cannot marry (5.6%), HIV/AIDS is from witchcraft (2.9%), no drug can cure HIV/AIDS (2.9%), and HIV/AIDS is treated traditionally (2.9%).

Research Question 2

Do cultural factors and traditional practices affect the attitude, beliefs and myths about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts?

Table 2: Frequency of the respondents on cultural factors and traditional practices that affect the attitude, beliefs and myths about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts

S/N	Items	Frequency	Percentage	Decision
1	Tattooing	42	17.4	Significant
2	Tribal marks	98	40.7	Significant
3	Scarification	22	9.1	Lowly Significant
4	Beard and hair shaving	53	22.0	Significant
5	Others	26	10.8	Significant

Below 10.0% = lowly significant; 10 – 49% = significant; 50% and above highly significant

The result in Table 2 showed the cultural factors and traditional practices that affect the attitude, beliefs and myths about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts. It further showed that tattooing, tribal marks, beard and hair shaving and others had significant effects cultural factors and traditional practices affect the attitude, beliefs and myths about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts, while scarification had low significant effects

Research Question 3

Do patients know how to access voluntary counselling/testing and antiretroviral therapy?

Table 3: The knowledge of access to voluntary counselling and testing and access to antiretroviral therapy

	Items	**Yes**	**No**
1.	Have heard of voluntary counselling and testing (VCT/HCT)	160(66.9%)	79(33.1%)
2.	Do you desire to be tested	138(59.4%)	94(40.5%)
3.	Have you ever been tested for HIV/AIDS	179(75.8%)	57(24.2%)
4.	Do you think HIV/AIDS can be prevented?	203(85.7%)	34(14.3%)
5.	Do you think the drugs used for HIV/AIDS treatment are effective?	185(97.7%)	47(20.3%)
6.	Do you think the educational and economic status of a person can affect his knowledge about voluntary counselling and testing (VCT/HCT)	131(55.5%)	105(44.5%)

The result in Table 3 showed the knowledge of access to voluntary counselling and testing and access to antiretroviral therapy. It further showed that 160(66.9%) of the respondents agreed that they have heard of voluntary counselling and testing (VCT/HCT), while 79(33.1%) disagreed. 138(59.4%) of the respondents agreed that they desired to be tested while 94(40.5%) disagreed. 179(75.8%) of the respondents agreed that they have been tested for HIV/AIDS while 57(24.2%) disagreed. 203(85.7%) of the respondents agreed that they think HIV/AIDS can be prevented while 34(14.3%) disagreed. 185(97.7%) of the respondents agreed that they think the drugs used for HIV/AIDS treatment are effective while 47(20.3%) disagreed. 131(55.5%) of the respondents agreed that they think the educational and economic status of a person can affect his knowledge about voluntary counselling and testing (VCT/HCT) while 105(44.5%) disagreed.

Hypothesis 1

Cultural factors and traditional practices about HIV/AIDS do not significantly affect patients in public hospitals in Delta south and north senatorial districts based on educational qualification.

Table 4. Mean and standard deviation on Cultural factors and traditional practices about HIV/AIDS. based on educational qualification

Education qualification	N	Mean	Standard Deviation
Primary	25	27.08	5.338
Secondary	86	28.52	5.257
Tertiary	130	29.77	5.603
Total	241	29.05	5.504

The result in Table 4 showed the mean and standard deviation as 27.08 and 5.338; 28.52 and 5.257; and 29.77 and 5.603 respectively for patients with primary, secondary and tertiary educational qualification.

Table 5: The Analysis of variance (ANOVA) of mean and standard deviation on Cultural factors and traditional practices about HIV/AIDS based on educational qualification

	Sum of Squares	df	Mean Square	F	Sig.	Remarks
Between Groups	188.128	2	94.064	3.161	.044	Significant
Within Groups	7082.370	238	29.758			
Total	7270.498	240				

The result in Table 5 showed an F value of 3.161 and a p value of 0.044. Testing at alpha level of 0.05, the p value is greater than the alpha level. Therefore, the null hypothesis which stated that "Cultural factors and traditional practices about HIV/AIDS do not significantly effect patients in public hospitals in Delta south and north senatorial districts based on educational qualification" was rejected. Consequently, there is a significant difference in the attitude of patients in public hospital in south and north senatorial district of Delta state, towards the cultural factors and traditional practices about HIV/AIDS based on educational qualification.

Table 6: Multiple Comparisons (LSD) of the Cultural factors and traditional practices about HIV/AIDS among patients based on educational background

(I) Educational qualification	(J) Educational qualification	Mean Difference (I-J)	Sig.
Primary	Secondary	-1.443	.245
	Tertiary	-2.689*	.025
Secondary	Primary	1.443	.245
	Tertiary	-1.246	.102
Tertiary	Primary	2.689*	.025
	Secondary	1.246	.102

*The mean difference is significant at the 0.05 level.

The result in Table 6 indicated that the mean difference of patients with primary and secondary education background was -1.443 with a p value of 0.245. The mean difference of patients with primary and tertiary education qualification was -2.689 with a p value of 0.025. This implied that a significant difference existed between patient with primary and tertiary educational background on the Cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta South and North Senatorial Districts in favour of those with tertiary education. The table further showed that no significant difference existed between patients with tertiary educational qualification and those with secondary educational background on the Cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta South and North Senatorial Districts

Hypothesis 2

Cultural factors and traditional practices about HIV/AIDS do not significantly affect patients in public hospitals in Delta south and north senatorial Districts based on socio-economic status.

Table 7: Mean and standard deviation on the Cultural factors and traditional practices about HIV/AIDS. based on socio economic status

Socio Economic Status	N	Mean	Standard Deviation
Unemployed	75	29.53	6.295
Employed	99	28.83	5.425
Unskilled	6	26.17	2.137
Skilled	61	29.08	4.758
Total	241	29.05	5.504

The result in Table 7 showed the mean and standard deviation as 29.53 and 6.295; 28.83 and 5.425; 26.17 and 2.137; and 29.08 and 4.758 respectively for patients that were unemployed, employed unskilled and skilled.

Table 8: The Analysis of variance (ANOVA) of mean and standard deviation on the Cultural factors and traditional practices about HIV/AIDS based on socio economic status

	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**	**Remarks**
Between Groups	72.327	3	24.109	.794	.498	Not significant
Within Groups	7198.171	237	30.372			
Total	7270.498	240				

The result in Table 8 showed an F value of 0.794 and a p value of 0.498. Testing at alpha level of 0.05, the p value is greater than the alpha level. Therefore, the null hypothesis which stated that "there is no significant difference on the cultural factors and traditional practices about HIV/AIDS among patients in public hospitals in Delta south and north senatorial districts based on socio-economic status" is retained.

DISCUSSION

Result of the research questions revealed that, the cultural and tradition practices of the people of Delta State are shrouded in myth. The views of the people are greatly influence by their cultural and traditional practices. The result also reported that the people are knowledgeable about the voluntary counselling, testing and antiretroviral drugs. Perhaps the ascending increase of HIV/AIDS in Delta State may be due to the high rate of illiteracy and ignorance of the indigenes.

Also, the result in hypothesis 1 revealed that, the cultural factors and the traditional practices have significant bearing on how the educated patients react to HIV pandemic in two senatorial districts being examined. The result corroborates with the assertion of Iyamu and Alika (2011) that, prevailing belief and myth can affect any persons not minding their levels of education. However, Kitara (2012) differs. The researcher posited that cultural belief system has no impact on educated individuals. Rather, illiteracy and ignorance propel the increase of HIV.

However, hypothesis 2 revealed that the socio-economic status of the patients in the public hospital in the senatorial districts under study has nothing to do with the cultural factors and traditional practices about HIV/AIDS. Cultural and traditional practices of the people of Delta state have no bearing on the unemployed, employed, unskilled and

skilled patients in the two senatorial districts under study. Nwaorgu (2009) agreed with this view, the researcher stated that, there is no disparity among gainfully employed, unemployed, skilled and the unskilled towards the pandemic. As they still maintain multiple sex partners and engage in casual and unprotected sex. However, the analysis of Monjok, et al (2009) showed that over four million Nigerians have contacted AIDS virus perhaps due to the poor control strategy, poverty level low educational background. Reports from other researchers, envisaged serious danger in the nearest future, as the disease is being carelessly handled by many Nigerians specifically in Delta State (Fernades,2013, Oduenyi, Ugwa, Ojukwu & Ajasigwe 2019)

CONCLUSION

The study thereby concludes that, cultural and traditional practices are prevalence in Delta state. These practices have positive impact on the educated patients and that the disease is been treated with less than no honest approach by the populace in Delta state. This may spell doom for the community if not addressed.

RECOMMENDATIONS

The followings recommendations were made:

a. That the DELSACA and NGOs (IPS) in Delta State should educate patients and the general public through electronic and mass media about HIV/AIDS.

b. Sex educations should be included in the secondary school curriculum to educate youths early enough about the dangers in HIV/AIDS and the benefits of abstinence and being faithful to a partners.

c. Counselling deprtments should be establihed in public hospitals in Delta State with trained counsellors employed.

d. Stigmatizations of people having HIV/AIDS must be discouraged at all sector of the society since stigmatization decreases linkages to care of patients with HIV/AIDS.

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