Influence of Primordial Culture and HIV/AIDS Awareness Programme on Stigmatization of HIV/AIDS Patients in Oyo and Osun States, Nigeria: Premise for Community Education Intervention

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Abstract

The study examined the problem of stigmatization of HIV/AIDS patients in Nigeria. A descriptive survey design was adopted for the study. Two hypotheses were generated to test possible influence of primordial culture and component of awareness of HIV/AIDS on stigmatization of HIV/AIDS patients. The population of the study consisted of male and female respondents from two communities in Oyo and Osun States, Nigeria. A total of 275 respondents were selected through stratified random sampling technique. A questionnaire tagged “Stigmatization of HIV/AIDS patients and Community Education Questionnaire (SHAPCEQ)” was designed for the study. The data collected were analyzed, using frequency counts, percentages and chi square statistical method. Findings showed that primordial culture influenced attitude to HIV/AIDS patients ($\chi^2 = 7.69, P<0.05$). Also, the initial components of the awareness of the deadly disease contributed to the stigmatization ($\chi^2 = 50.3569, P<0.05$). Based on these findings, it was recommended that community education strategies should be intensified to reduce stigmatization of HIV/AIDS patients.

Introduction

Human Immune-Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) has spread to every nation since it was reported two decades ago. Africa, and indeed Nigeria, has suffered the devastating effect of the ravaging virus. The international bodies have been putting in extra efforts through researches, seminars, workshops and direct assistance to the general public and, especially to the victims in order to curtail the spread. Efforts are also geared towards finding solutions to the problem. In effect, UNDP, UNESCO, UNFPA, UNODC, WHO, and UNAIDS have given support to national governments for advocacy to stop the spread. United Nations Development Programme (UNDP), United Nations Educational Scientific and Cultural Organization (UNESCO) United Nation (UN), World Health Organizations (WHO), United Nations Programme on Aids (UNAIDS). Nigeria has taken up the challenge and set up the National Action Committee on Aids (NACA) with the support of UNAIDS. The emphasis is on preventive education, especially through the Ministry of Education at the Federal and State levels.

HIV/AIDS has devastating effects on the economic status of the infected and affected persons by accelerating poverty, preventing good health, retarding good quality education as well as social and political progress of nations. In 2002, about 5 million people acquired HIV, 3 million died, while 42 million people are living with the virus out of which 3.6 millions are Nigerians. So far about 1.7 million Nigerians have died of the disease (UNESCO, 2003). Due to new discoveries, the patients of HIV/AIDS can now live longer and be active as every other human being. However, they suffer stigmatization and discrimination in their communities.
Stigmatization

Stigma is an attribute that is deeply discrediting and reduces the possessor’s value in the minds of the beholder (Goffman, 1963). There are three types of stigma—those arising from abominations or abnormalities of the body (2) those due to flaws of the character of the person, and (3) tribal stigma which arises from prejudices between different ethnic or social groups. HIV/AIDs can be regarded as leprosy. It creates feelings, of remorse, recrimination, apathy, resignation and even thoughts of suicide. Jowett and Ryan (1985) stated that even persons with non-infectious skin conditions such as eczema and acne are stigmatized, and they thereby suffer from psychological problems such as shame, anxiety and lack of self-confidence.

Stigma has a social cost. To cope with perceived stigma, affected persons may resort to behavioural dependencies and attitudinal dispositions such as keeping away or denying the effects that the condition is having on their well-being. Affected persons might feel resented, useless, ashamed and ridiculed. Kolawole (2006) reported cases of discrimination and stigmatization against people living with HIV/AIDs in churches, society and generally in their communities. He cited incidents of cruel and degrading attitudes, refused and/or termination of employment, denied right to marriage, rejection by families, friends, churches, mosques and other religious organizations, suffered by victims.

In some societies, laws, rules and policies can increase the stigmatization of people living with HIV/AIDs. Such legislation may include compulsory screening and testing as well as limitations on international travel and migration (www.avert.org/aid_stigma.htm) 2006 Stigma and discrimination can arise from community level response to HIV/AIDS. The harassment of individuals suspected of being infected has been witnessed in Colombia, Ethiopia, India, South Africa and Thailand. Families are primary care givers to sick members in most African nations. However, the fear of infection makes many family members keep away and stigmatize the patient. Moreso, members of the family also suffer stigmatization or discrimination within the community for having a member who is HIV/AIDs positive. This could be traced to the culture which expects each extended family to have certain honour and respect.

Olori (2002) reported the views of Jerome Mafeni, a member of the World AIDS Day organizing committee. Mafemi believed that messages that HIV/AIDs is a dreaded disease that dries people and pictures of emaciating victims from hospital about a disease without a cure means a death sentence. The information scared people and made them avoid anyone that tested positive. Sampson (2006) suggested a legislative action to curb stigmatization. He felt that Nigeria needs a legislation to prohibit discrimination against people living with HIV/AID. This will make it an offence for any person to discriminate against those affected by HIV/Aids. In “Things fall Apart” by Chinua Achebe, the story of how Nnoka ended his life in the evil forest was recounted. He was stigmatized and cast into the forest because of disease of swollen bowel, which the community perceived to have manifested due to act of wrath of gods.

Primordial Culture

Culture is developed after birth. Man acquires the prevailing attitudes and beliefs, the focus of behaviour appropriate to the social roles he occupies and the behaviour patterns and the value of the society into which he is born. Anyanwu(1999) also argued that culture constitutes the answer to the need for adaptive behaviour in man and is a patterned activity
humanly invented and discovered and socially shared and transmitted from individual to individual and from generation to generation.

The traditional primordial culture is a way of life or attitude developed through cultural practices or orientation, which have effects in determining patterns of behaviour within the community or towards certain programmes. Culture could be traced to inherited values, which are the chain of continuity within a social group. In confrontation with modernity in Nigeria, people bring with them cues drawn from their own cultures, responses they (or do not) make, their ability to adaptability or otherwise can be traced to their indigenous attitude and orientations (Eleazu, 1977, Abiona, 2003).

Community Education

The ultimate goal is to develop a process by which members of a community may learn to work together to identify problems and seek solutions to such problems. This can be achieved through community education. Community Education is not dependent on the attendance of school. The school is just one of the delivery systems through which the concept may be carried out. Thus, the school becomes most effective for community education when it involves the people in designing programmes and in providing opportunities for the educational systems. Moreover, community education derives from educational theory, which applies as much to adult education as primary, secondary and tertiary education and the voluntary sector.

Community education is to develop a process by which members of a community learn to work together to identify problems and to seek solutions to these problems. The contention is that it is through this process that an on-going procedure is established for working together on all community issues. Minzery and le Tarte (1972) and Fetcher (1980) defined community education as a process of commitment to the education and leisure of all ages through local participation in setting priorities, sharing resources and the study of circumstances. Community education transcends all levels of education and concerns itself with everything that affects the well-being of all citizens within a given community.

Even traditional community education serves the needs of the community. According to Anyanwu (2002) traditional community education in Nigeria was an instrument of social stability as it was the effort of the various communities to perpetuate them. It was designed to enable the individual to become an integral part of the cultural life in which he lived. The Nairobi Declaration on Community Education at the Fifth World Conference in Kenya (1987) stated that education is not only learning how to read, write, add or subtract, though these are important elements of the educational process. Community Education must support the task of making people-children, youth, adults-aware of their identify as a people and of their problems (like stigmatization) needs and aspirations and their resources as a community.

Statement of the Problem

Stigmatization of HIV/AIDS patients is a global problem which needs immediate action. However, the influence of primordial culture and attitude due to initial fear of the disease has not been fully examined. This study, therefore, focused on the possible causes of stigmatization of HIV/AIDS patients and possibility of community education intervention to solve the problem.

Objectives of the Study

The objectives of this study are to:
i. examine the influence of primordial culture on attitude to stigmatization (of HIV/AIDS patients);
ii. investigate the impact of initial awareness campaign against HIV/AIDs on attitude to stigmatization; and
iii. suggest possible community education strategies to reduce the stigmatization.

Scope of the Study
This study examined the problem of stigmatization of HIV/AIDs patients in Oyo and Osun States, Nigeria and possible reduction through community education intervention. Selected communities in Apomu (semi urban) in Osun State and Ibadan (urban) in Oyo State in Nigeria.

Significance of the Study
The study would provide an insight into some of the causes of stigmatization of HIV/AIDs patients. It would help policy makers to find solution to the causes. It would also create an awareness of community education to solve community problem locally. It would assist the various agencies, both locally and internationally to reduce stigmatization through community education.

Hypotheses:
Two null hypotheses were formulated and tested to guide the conduct of this study at 0.05 level of significance.

H01: There is no significant relationship between the sensitization programme and stigmatization of HIV/AIDs patients.
H02: There is no significant relationship between the primordial culture and stigmatization of HIV/AIDs patients.

Methodology
The design: The descriptive survey design was adopted for this study. Independent variables were primordial culture and awareness campaign, while dependent variable was stigmatization. The respondents for this study consisted of 275 respondents drawn from Ibadan an urban centre, in Oyo State and Apomu a (semi urban) town in Osun State, Nigeria. The respondents were made up of 132 male and 143 female.

Instrumentation
A questionnaire tagged Stigmatization of HIV/AIDs Patients and Community Education Questionnaire (SHAPCEQ) was designed to elicit necessary information from respondents, on the influence of primordial culture and awareness of programme on stigmatization. The questionnaire was structured and open ended. The test re-test value of the questionnaire with the final questionnaire gave a correlation of 0.86. This meant that the instruments was both valid and reliable for this study. The questionnaire (SHAPCEQ) was divided into two sections. The first part was on the demography of the respondents while the second part elicits information on stigmatization, primordial culture and awareness of HIV/AIDs.

Data Analysis
The data on demography of the respondents were analysed, using simple percentages while chi square ($X^2$) was used to test the hypotheses generated for the study.

Table 1: Frequency and Percentage Distribution of Respondents Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Urban</th>
<th>Semi-Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>46</td>
</tr>
<tr>
<td>Female</td>
<td>99</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>

From Table 1, 54% of the respondents in urban (Ibadan) were female while 46% were male. Also 52% of the respondents in semi urban (Apomu) were female while male respondents were 48%. This indicates that women are more concerned about the possible effect of HIV/AIDS on human beings. This might be due to the fear that more women are victims of the disease.

Table 2: Frequency and Percentage Distribution of Respondents by age

<table>
<thead>
<tr>
<th>Age</th>
<th>Ibadan</th>
<th>Apomu</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>10-19 years</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>20-29 years</td>
<td>34</td>
<td>18</td>
</tr>
<tr>
<td>30-39 years</td>
<td>63</td>
<td>35</td>
</tr>
<tr>
<td>40-49 years</td>
<td>56</td>
<td>30</td>
</tr>
<tr>
<td>50 years</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2 shows the different age groups of the respondents. The highest number of respondents was in 30-39 years bracket in both communities. In urban (Ibadan) 35% of the respondents were in age group while 32% of the same age group 30-39yrs was recorded in semi-urban (Apomu). Between 18% and 21% of respondents were in 20-29 age group in both communities respectively. Thus, the age group 20-49 years constitutes the most active years sexually.

Table 3: Distribution of Respondents by Marital Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Urban</th>
<th>Semi Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Single</td>
<td>59</td>
<td>32</td>
</tr>
<tr>
<td>Married</td>
<td>113</td>
<td>61</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Widow</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>184</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3 reveals that 32% of the respondents in the urban centre (Ibadan) and 21% in the semi-urban (Apomu) are single. Also 61% in the urban and 74% in the semi-urban (Apomu) areas are married. This shows that marital institution is more cherished in (semi-
urban) area than urban. This might be due to great attachment to the culture of the people by those in semi rural areas.

Table 4: Percentage Distribution of Respondents by Education

<table>
<thead>
<tr>
<th>Levels of Education</th>
<th>Urban</th>
<th></th>
<th>Semi-urban</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Illiterate</td>
<td>3</td>
<td>1.6</td>
<td>35</td>
<td>38.0</td>
</tr>
<tr>
<td>Primary/Adult literacy</td>
<td>10</td>
<td>5.4</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>22</td>
<td>12.0</td>
<td>20</td>
<td>22.00</td>
</tr>
<tr>
<td>Tertiary</td>
<td>143</td>
<td>77.7</td>
<td>17</td>
<td>18.7</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>3.3</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>100</td>
<td>91</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4 displays the level of education of respondents and which has bearing on stigmatization of the patients. The semi-urban area has a higher percentage of illiterates (38%) compared with the urban centre 1.6%. The urban area has more educated people of different categories as shown in the table. The implication is that those in urban centre have more access to western education and, therefore, might not be seriously affected by the customs of the society.

Testing of hypotheses and Findings

**H₀**: There is no significant relationship between sensitization programme and HIV/AIDS victims stigmatization.

Table 5: Contingency Chi-Square on relationship between sensitization and stigmatization attitudes of respondents

<table>
<thead>
<tr>
<th>Calculated</th>
<th>Degree of Freedom</th>
<th>Critical Value</th>
<th>P</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.35</td>
<td>6</td>
<td>12.59</td>
<td>0.05</td>
<td>S</td>
</tr>
</tbody>
</table>

Significant at P<0.05 X² 50.35

The table 5 indicates that there is a significant relationship between sensitization programme on HIV/AIDS and attitude towards the disease. Through the various sensitization programmes, the respondents claimed to have knowledge of HIV/AIDS, cause, effects and implications on victims and their communities.

Findings show that the respondents had fear that the disease is contagious and whoever suddenly goes lean might be a victim of HIV/aids. There is awareness that the disease exists and deadly, hence the attitude towards it is to avoid interaction with those known or can be identified as being promiscuous in the community. Finding further revealed that despite the awareness of reality of the disease, most respondents would not be too willing to go for HIV/AIDS screening. Even when there is knowledge of causes of the disease, respondents do not freely interact with affected persons. The findings agree with views of Jewett & Ryan (1998) that sensitization might affect the general attitude towards the disease.
**H0**: The primordial culture has no significant relationship with attitude towards HIV/AIDS’ patient.

**Table 6**: Chi-Square on Effect of Primordial Culture on Attitude towards AIDS Patient

<table>
<thead>
<tr>
<th>Calculated $X^2$</th>
<th>Degree of Freedom</th>
<th>Critical Table Value</th>
<th>$P$</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.69</td>
<td>2</td>
<td>5.99</td>
<td>0.05</td>
<td>S</td>
</tr>
</tbody>
</table>

Significant at $P<0.05$ $X^2 = 7.69$

Table 6 indicates that there is a strong relationship between attitude towards AIDS patients and primordial culture. The table indicates that the cultural belief is significant hence, the hypothesis is rejected.

Findings indicate that despite the sensitization programme and various means in contacting the disease, the cultural belief that any one with a deadly disease should be treated as an outcast still prevails in both urban and semi-urban areas. Once symptoms identified with AID manifest, whether the disease is confirmed or otherwise, a person affected suffers stigmatization. Even the family members find it difficult to relate freely with the patient for fear of infection. Moreover, not only the patient suffers stigmatization, all members of his/her family are stigmatized. No one would think of marrying into that family or associate with them. This is basically on the type of communal tie and tradition that exist among the Yoruba community and Africans. In Yoruba culture, before wedlock is celebrated, there is a research into the family background of the bride and bridegroom.

**Discussion of Findings**

(i) Findings indicate that the respondents’ level of awareness on existence and effects of HIV/AIDs is high. However, the knowledge of the causes is not deep enough. People still believe that holding hands, insect bite, walking together can bring infection. The initial sensitization on HIV/AIDs has made many of the respondents develop a fear for the disease, more so that there is no present cure for it. The attitude exhibited by the respondents agrees with the attitude noted in a similar research conducted by Jawett & Ryan (1985). It shows that attitude towards the same phenomenon can be worldwide. Moreover Olori (2002) believed that the messages about the disease make people scared and avoid anyone that tested positive to the disease.

(ii) It was further revealed that primordial culture affects the attitude towards the patients. This implies that stigmatization suffered by the patients has its roots in primordial culture. The traditional belief about victims of deadly diseases being excommunicated has affected attitude towards HIV/AIDS patients. This finding agrees with findings in a research conducted on possible cultural attitude towards victims of guinea worm by Brieger, Oshiname and Ososanya (1997). Also, the submission of Apter (1967) that is often difficult to change primordial attitude and embrace new orientation holds here.

(iii) Moreover, the level of education and sensitization on stigmatization is too low to make people change their attitude. Enough efforts in term of information dissemination, especially at the grassroots level to make people more knowledgeable on caring for the patients at the grassroots can create attitudinal change Aboyade (1987).
Also, community education process in finding solution to such global problem with local approach has not been put into action in Nigeria. At the Fourth International Community Education Conference held in Dublin Ireland in 1983, it was declared that “Think Globally, Act Locally” Community education being a local action can intervene in a global problem such as stigmatization.

Conclusion
This study has established that there is a close relationship between the attitude of the respondents and initial HIV/AIDS sensitization programme. Also, the primordial culture of the community affects attitude towards the patients with HIV/AIDS. It is, therefore, advocated that community education which can solve such a global problem through local approach be employed.

Recommendations
The following are recommended to reduce stigmatization of and discrimination against HIV/AIDS patients and moreover, to improve care giving to the patients.
1. All channels of community education such as primary, secondary, tertiary, adult literacy centers, non-formal and informal education should serve as avenue to sensitize the community on infection of HIV/AIDS.
2. Through community education, people should be involved in combating stigmatization of HIV/AIDS patients.
3. The cultural communication channels such as gong, elders, forum and meetings should serve the rural communities.
4. Life-long Community Education is adopted. These include communal, church, and mosque, meeting. Legislating against discrimination of HIV/AIDS patients might not solve the problem in Nigeria, going by the experience of what is happening currently in the nation.

Community education enables a global thinker of problems, but local action to find solution in order to satisfy needs and aspirations of that community.

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Jowett & Ryan 1985 cited in Brieger WR, Oshiname F & Ososanya, O: 1998 Stigma Associated with on Chocerical Skin Disease Among those Affected Near the Ofiki and Oyan rivers in Western Nigeria: Social Sciences and Medicine Module in African Regional Health Education Centre, College of Medicine University of Ibadan, Ibadan, Nigeria.

