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Social Dynamics of Hiv/Aids Epidemiology and Potential for Escalation in Delta State, Nigeria

John Lekan Oyefara, Phd*

Department Of Sociology,Faculty Of Social Sciences

University Of Lagos,Akoka, Yaba, Lagos, Nigeria

E-Mail: Oyefara@Yahoo.Com

Loyefara@Unilag.Edu.Ng

Abstract

The article examines the prevalence rate of HIV in the oil-rich Delta State, Nigeria and its potential for escalation within the existing socio-cultural context in the State. The research design adopted was a triangulation of both in-depth interview and documentary data. The study discovered relationship between increasing volume of production activities of the oil companies in Delta State with associated social change and social dynamics and increase in the transmission of the virus. Various indicators examined suggest potential for escalation if existing efforts designed and implemented are not sustained. There is a need to consider balancing HIV/AIDS programmes between rural and urban areas in the State. In conclusion, stakeholders working on HIV/AIDS in the State need to engage in periodical assessments of existing programmes in order to foreclose areas of deficiency in the various methods and techniques designed to prevent and ameliorate the impact of the pandemic in the State.

Key words: HIV/AIDS, Epidemiology, Social Dynamics, Potential for Escalation, Delta State, Nigeria

Introduction

AIDS remains one of the major causes of death of our contemporary time. The scourge has killed millions of people worldwide, and it has not stopped in wrecking its havocs on human population. Since its discovery about four decades ago, HIV and AIDS have increasingly led to the decimation of human population and AIDS has eventually caused the death of millions of people, living in its wake many orphans and widows. As it is today, nobody has been able to come up with a cure of this global epidemic. This indeed, is not a cheering news for the whole world, most especially those already infected by the virus. The International community along with governments at all levels and non-governmental organizations (NGOs) have spent billions of Naira to see to the eradication of the virus in Nigeria especially among the most vulnerable groups. In 2007, the United Nations Action on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) reported that at the end of 2007, the global community could boldly say that most efforts put at reducing HIV infection worldwide are yielding positive results. Two of these positive developments include the designing of new methodologies that can discern HIV/AIDS prevalence and reports of downward trend in the rate of transmission of the virus all across the continents. UNAIDS and WHO, however cautioned that, despite the global advances made on funding, research and policy intervention, sub-Saharan Africa still remains the largest home for HIV/AIDS infected persons, and it is the region with the highest case of AIDS deaths. According to these international organizations:

> *Sub-Saharan Africa remains the most affected region in the global AIDS epidemic. More than two thirds (68%) of all HIV-positive people live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred. It is estimated that 1.7 million (1.4 million-2.4 million) people were newly infected with HIV in 2007 bringing to 22.5 million (20.9 million-24.3 million) the total number of people living with the virus in the region. Unlike other regions, the majority of people living with HIV in sub-Saharan Africa (61%) are women. Nigeria is one of the countries with largest epidemic in this sub-region. The national HIV prevalence among women attending antenatal clinics in Nigeria appears to be stable, but with large variation between different regions and States State-wide HIV prevalence among pregnant women, for example ranges from as low as 1.6% in Ekiti (in the West) to 8% in Akwa-Ibom (in the South) and 10% in Benue in the North-Central (UNAIDS and WHO, 2007:13-18).*

It is important to note that in the case of Nigeria, the international community and the federal government have general concern for the consequences of increasing activities of oil multinationals on the economy and demographic dynamics in the Niger Delta region of the country. Delta State is one of the key states in the Niger Delta, and its centrality revolves around the fact she is one of the States in the region with much oil mineral resources, that has the capacity to contribute significantly to the global capitalist system. Thus, the concern about HIV/AIDS problem in the Delta State is born out of the desire to reduce the number of people likely to be vulnerable to HIV transmissions within the State in the next decades. One trend that has been observed by experts in the field is that certain forces - socio-cultural, economic, political, industrial, traditional etc are likely to determine the patterns of HIV/AIDS and its prevalence rate in a particular community, town or even a country. In most developing countries of the world, it has been observed that activities of oil producing multinationals have had mixed results for HIV prevention and control most especially in the host communities were their operations are located. Considering this context, this article examines the incidences and prevalence of HIV in Delta State within the past decades with attempts to gauge the State specifics of the pandemic in Nigeria. One of the reasons of doing this is to understand the dynamic of the virus in the State which will invariably guide the stakeholders on how to stem the pandemic in the State.

Socio-Cultural and Development Context of Delta State

Delta State is located in the South-South region of Nigeria. It is one of the richest oil producing states in Nigeria. Delta State was created on August 27th, 1991 by the Military regime of General Ibrahim Babangida (Rtd.). The state was carved out of the defunct Bendel State, which eventually made it one of the nine new states created then. At inception, Delta State had twelve (12) Local Government Areas (LGAs) but a month later on September 27th, 1991 the number was increased to nineteen (19). Presently, the number of LGAs in the State is put at twenty-five (25). Delta State lies roughly between longitude 5° 00' and 6° 45' east and latitude 5° 00' and 6° 30' north. It is bounded on the North by Edo State, on the North-West by Ondo State, Anambra State on the East and Rivers State on the South-East. On its southern flank is the Bight of Benin which covers approximately 160 kilometres of the state's coastline. Delta State is generally low-lying without remarkable hills and has wide coastal belt inter-laced with rivulets and streams which form the Niger-Delta. The River Niger washes the eastern and south eastern boundaries of the state with Asaba, the capital, located at its bank.

The major ethnic groups are Isoko, Itsekiri, Izon, Igbo and Urhobo. The groups speak corresponding languages. All the ethnic groups have many things in common with some of them claiming a common ancestry. Their system of traditional administration tends to be identical; so also are their modes of traditional worship. Perhaps, because of their claim to common ancestry, many of the people in the State have similar cultures easily discernible in their traditional modes of worship, folklore, dances, festivals, arts and crafts. Such claims further lend historical credence to the fact that many of the ethnic groups are said to have migrated from Benin, the heart of the ancient Benin empire. The 2006 national population census (final figure) puts the population of Delta State at 4,112,445 made up of 2,069,309 males and 2,043,136 females.

Delta State is blessed with 12 higher institutions namely: Federal University of Petroleum Resource, Effurun; Delta State University (Abraka Campus, Oleh Campus, Asaba Campus); Ogwashi Uku Polytechnic; Otefe Oghara Polytechnic; Ozoro Polytechnic; College of Education (Agbor Campus, Warri Campus); Federal College of Education Technical, Asaba; College of Physical Education, Mosogar; College of Health Technology, Ughelli; Petroleum Training Institution, Effurun; Western Delta University, Oghara; and Novena University, Ogume. As stated earlier, Delta State is a major oil producing State in Nigeria and ranks second to Rivers State. The State supplies about 35% of Nigeria's crude oil and some considerable amount of natural gas. The oil producing local government areas are Warri North and South, Burutu, Isoko North and South, Ughelli North and South, Okpe, Ethiope East and West, Sapele and Ndokwa East and West. The nation's second refinery as well as petrochemical plant are located at Warri in the State. Within these socio-cultural, economic, demographic and development contexts, this paper examines the social dynamics of epidemiology of HIV/AIDS and the potential for its escalation in the State.

Research Methods

A triangulated research design was employed to generate both primary and secondary in the study. The research methods adopted in this design include in-depth interview and documentary technique. The combination of these methods which is eclectic in nature provides opportunity to generate data from multiple sources which invariably improve the reliability and validity of collected data. Information on each of these methods was summarized as follows:

In-Depth Interview: Respondents for in-depth interviews were different stakeholders in the management and control of HIV/AIDS in Delta State. These stakeholders are: the general populace, Non-Governmental Organizations (NGOs)/Community Based Organizations (CBOs) working in the areas of HIV/AIDS in the State, the programme manager of Delta State Action Committee on AIDS (DELSACA) and other relevant officers in the organization, People living with HIV/AIDS (PLWHA) and youth/women groups. These respondents were sampled for In-depth interview in order to

document their knowledge and perception about HIV/AIDS epidemic and its management in Delta State. Consequently, people within the urban and rural areas including various stakeholders working in the areas of HIV/AIDS in the State were adequately represented. It is imperative to note that qualitative data were generated through this method.

Documentary method: Documentary which is a secondary source of data was used to elicit essential information on HIV/AIDS epidemic in Delta State and the State's response to the pandemic. Most of these secondary sources were national surveys organized by both local and international organizations and institutions. These sources are: Nigeria Demographic and Health Survey (2008), Antenatal Sentinel Surveys (ANC) (1991-2010) and National HIV/AIDS and Reproductive Surveys (NARHS) (2003-2007). In addition to these reports, the paper relied on documents provided by Delta State Ministry of Health and DELSACA on HIV prevalence and various intervention programmes developed and implemented to mitigate and ameliorate the impact of HIV/AIDS in the State. These documents were desk reviewed and various data were systematically and objectively generated for the article. All the various data in each of these reports are quantitative in nature, thus their research designs had statistical assurance of 95% confidence interval and their results can be generalized to the larger population in the State. With this level of critical confidence interval the analyses in this article explains the epidemiology of HIV/AIDS in Delta State in a more comprehensive way. The uniqueness of this article was ability to put together, various scattered data on HIV/AIDS epidemic in Delta State. This provides great opportunities to measure extent of HIV/AIDS problems and also suggest different pragmatic strategies to be adopted to stem the epidemic in the State in one article.

Sampling Method:Purposive sampling method was adopted to select various respondents for in-depth interview using the following strategies: First, Delta State was sub-divided into three senatorial districts namely: Delta Central, Delta North and Delta South and one research team (comprising of four research officers) was assigned to collect relevant information with regards to each of the objectives of the study in the senatorial district. This strategy provides opportunity for adequate representation of people from various segments of the State on the study. In all, a total of 30 respondents were interviewed purposively at this level. The justification for the adoption of this sampling method was based on the relevance, availability and adequate knowledge of individual interviewed to provide in-depth responses on the topic of the study. Probability sampling methods were adopted to generate various data in the various documents reviewed. These are clearly spelt-out in the methodology section of the stated reports.

Study Duration

The entire field work (collection of primary data using in-depth interview method) lasted for about five weeks. Precisely primary data collection commenced from February 1st to March 5th, 2011.

Quality Control and Method of Data Analysis

Various control measures were put in place in order to ensure the validity and reliability of the information generated. Field researchers were careful in the selection of respondents in order to meet the essential requirements stated in the research design and the various interviews were conducted in a confidential environment. In addition, the processed data were also subjected to vigorous quality control measures such as range checks and location specific random validation checks. The methods of data analysis are descriptive and comparative in nature. In doing the analysis, various data elicited from the three senatorial districts were pooled together with information from secondary sources and the data were analyzed using ethnographic content analysis technique.

Findings:

The presentation of findings had been grouped into five sub-sections. The first section examined the HIV prevalence rates in Delta State. In this section, this article examines the general trend of HIV prevalence, rural-urban differentials in prevalence and new incidence of HIV, and LGA

differentials in HIV prevalence in the State. The second section consists of data on HIV/AIDS related knowledge in the State. Three key issues were examined in the section. These are HIV awareness, knowledge of HIV prevention methods and HIV risk perception in Delta State. Section three investigates the practice of risk behaviour in relation to HIV. Issues discussed here include level of non-marital sexual intercourse, transactional sexual relationship and multiple non-marital intercourse among the entire population in the State. Section four considered the culture of the use of condom in Delta State, while section five delved into the socio-cultural context of HIV pandemic in the State. In the sixth section, the State response and response gap were identified and discussed. The final part of the articled discussed the various finding and the potential for escalation of the virus in the State. These sections will be taken respectively in the remaining part of the article.

1. HIV Prevalence Rates in Delta State

General Trend of HIV Prevalence in Delta State

One of the best ways of determining the intensity of the impact of HIV pandemic on the demographic profiles of a State is by looking at its prevalence rate. Although, many factors usually account for this, what is important is the trend analysis that will give experts required information in order to be able to make projections and predictions about the spread of the virus in the community or state so concerned. From Table 1 below, HIV prevalence rate in Delta state experienced its lowest rate (0.8%) in 1991/1992 but rose to 5.1% in 1993/1994. By 1995/1996, it dropped considerably to 2.3% meaning that there were some intervening variables checkmating its spread. In 1999, there was a dramatic rise of 4.2% and finally 5.8% in 2001, which happened to be the highest prevalence rate in the history of the State. Since this period, HIV prevalence rate in the State dropped to 5.0% in 2003, and further dropped to 3.7% in 2005 and 2008 respectively. Thus, it is instructive to note that HIV prevalence rate in Delta State stabilized at 3.7% in 2005 and 2008 and subsequently increased to 4.1% in 2010.

Table 1: Percentage distribution of respondents by HIV prevalence rates

Year	HIV Prevalence Rate
1991/1992	0.8
1993/1994	5.1
1995/1996	2.3
1999	4.2
2001	5.8
2003	5.0
2005	3.7
2008	3.7
2010	4.1

Source: Federal Ministry of Health (1992, 1994, 1996, 1999, 2001, 2003, 2005a, 2008, 2010) The National Sentinel Survey on HIV/AIDS & STIs.

It is pertinent to note that differences in the years must have been accounted for by different factors embedded in the changes in population size, and changes in the demographic profiles of members of the State. For instance, one of the factors that opinion leaders have identified as a motivating factor was the sharp increase in the volume of business activities in the Niger Delta areas orchestrated by mass movement of foreign oil merchants into the Niger Delta region in Nigeria. As argued by male political elite in Asaba the State capital during the in-depth interview session, he stated that:

> *It is a truism to state that Niger Delta is the region where petroleum oil-the main resource of Nigeria-is domiciled, if there is any other region where we can find it; the quantity and quality are questionable and insignificant to the one in Niger Delta. Delta State is one of the States in the region. Since the discovery of petroleum oil, the economic base of the people in the region has been greatly altered and significantly modified. Agriculture and fishing activities have been hampered due to oil exploration and attendant environmental pollution and degradation. Expectedly, men, women and children who had been alienated totally from their communal and traditional means of livelihood are attracted by the new labour markets; naturally they think of how they can fulfill their life desires in the face of hardship and constantly changing environment. The major disappointing issue is that available jobs in most of these oil companies were not given out to indigenes except you have considerable networks and connections. Women, most especially the young ones, in this type of situation might have to make use of what they have to get what they want by engaging in illicit sex with oil workers either local or foreign nationals. This situation and behaviour may aid rapid transmission of HIV.*

Another factor responsible for high susceptibility and vulnerability of people in Delta State to HIV infection was the drafting of soldiers and members of the armed forces to the Niger Delta for peace-keeping operations in order to fight the militants in the region. One community leader in Asaba during an in-depth interview asserted that:

> *The history of Niger Delta is the history of struggle. We struggle for survival and existence, generations yet to come and our communities. As you know, the killing and maiming of our elites and gross exploitation by political leaders during military era and early part of present democracy led to the emergence of militants. These young militants with sophisticated local and imported weapons kidnapped both foreign and local oil workers, the activities that threaten the economic base of Nigeria. In response to these activities, we have soldiers and other peace keeping and Para-military officers all around us. Because most times these officers would have to work outside their homes, for months they might not have the opportunity of meeting their wives let alone having normal sexual intercourse with them, consequently they normally have sexual intercourse with indigenous ladies and commercial sex workers. Hence they are like agents through which HIV transmission is increasing in the State. Since HIV virus is easily transmitted through illicit sex, members of the armed forces on peace keeping and the entire members of the community within their sexual network remain vulnerable groups. But thank God for the amnesty programme of President Umaru Musa Yar'Adua. Indeed, amnesty programme has reduced the culture of militancy and attendant kidnapping of oil workers in the region. In addition, the military presence has also reduced drastically. Possibly, we may experience a reduction in the transmission of the virus in the nearest future.*

These essential factors among other things are responsible for the observed prevalence rate of HIV in Delta State.

Rural-Urban Differentials in HIV prevalence rate and New Incidence in Delta State

The prevalence rates of HIV between urban and rural areas in the State have varied over the years based on the intensity of ecological changes in the area. As presented in Table 2 below, in 2005 and 2008, urban areas had more HIV cases with the prevalence rates of 4.5% and 3.7% respectively. However, the prevalence rate of the rural areas was lower (2%) in 2005 but rose to equal (3.7%) that

of urban by year 2008. What this data presents to us is the increase in the prevalence rate of HIV in the rural areas. This is also suggests that anti-HIV programmes need to be intensified in the rural communities in the State. A staff of local Non-Governmental Organization (NGO) in Warri explained the differentials in rural-urban prevalence of HIV in this way:

> *Based on available data at our disposal as NGOs working in the areas of HIV/AIDS in the State, HIV prevalence in Delta State skewed towards urban areas in relation to rural areas, but urgent attention also needs to be moved to rural areas because of the linkages between rural and urban areas in the State. Rural areas in the State are not closed communities they have constant social and economic interactions with urban areas. Thus, rural dwellers are vulnerable just like urban dwellers to HIV in the State. Efforts need to be put together to reach rural dwellers with appropriate and accurate messages based on the cultural beliefs of the people.*

In Table 2 below also, we have data on the prevalence rates of HIV among women aged 15-24 years which indicate the new incidence of the virus in both rural and urban locations in the State. For the urban areas, the prevalence rate increased from 5.0% in 2005 to 5.5% in 2008, while the figures for the rural areas were 3.7% and 2.7% respectively in the stated years. It can be gauged from this data that although the prevalence rates of HIV may be similar in both rural and urban areas, the new incidence rate in 2008 decreased in rural areas but slightly increased in urban areas in relation to 2005.

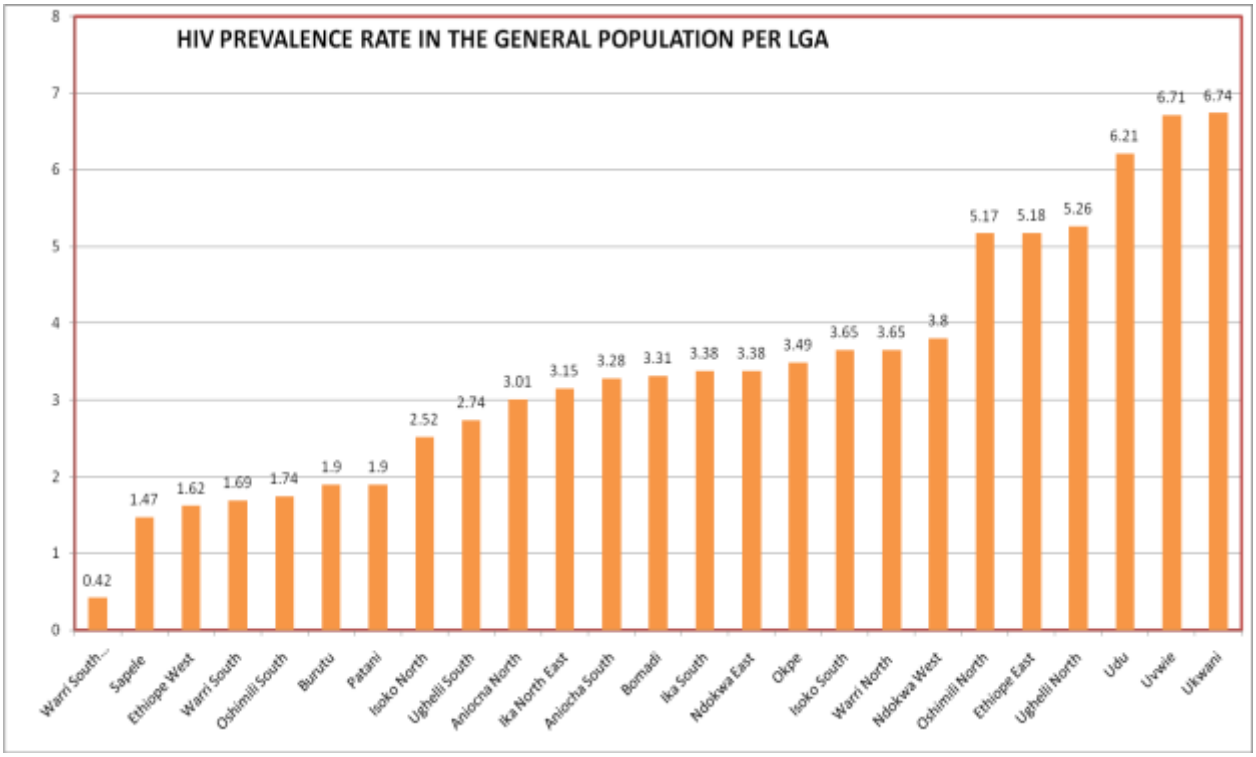
Table 2: Percentage distribution of respondents by HIV prevalence rates among women aged 15-24 year by place of residence

Year	Place of Residence	
	Rural	**Urban**
HIV Prevalence Rate by Place of Residence		
2005	2.0	4.5
2008	3.7	3.7
HIV Prevalence Rate among Women Aged 15-24 year by place of residence		
2005	3.7	5.0
2008	2.7	5.5

Source: Federal Ministry of Health (2005a, 2008) The National Sentinel Survey on HIV/AIDS & STIs.

HIV prevalence rates by Local Government Areas (LGAs) in Delta State

While there are observed variations in the prevalence rates of HIV in the urban and rural areas, there are also corresponding differentials across the 25 Local Government Areas (LGAs) of Delta State. The LGA with the lowest prevalence rate was Warri-South with 0.42% followed by Sapele and Ethiope West 1.5% and 1.6% respectively. The median rates started from Isoko North with 2.5% up to Ndokwa West with prevalence rate of 3.8%. However, the prevalence rates of Oshimili North, Ethiope East, Ughelli, Udu, Uvwie and Ukwani were the highest in the States. For instance, Oshimili North's prevalence rate was put at 5.17%, Ethiope East (5.18%), Ughelli North (5.26%), Udu (6.21%), Uvwie (6.71%) and Ukwani (6.74%) being the highest in the state. What these data present to us was that LGAs in rural areas have lower rates of HIV/AIDS cases than their urban counterparts.



Source: Delta State Action Committee on AIDS (DELSACA), 2011

2. HIV-related Knowledge in Delta State.

HIV Awareness and Knowledge of its Prevention

Majority of the populace in Delta State are aware of HIV and its modes of transmission most especially, the sexual transmission. In 2003, the percentage of those who said that they heard about HIV was lower than those of 2005 meaning that awareness has been increasing over the three years under review. In 2003, 73.6% of the people in the State said that they were aware that HIV is transmitted through sexual intercourse and the figure went higher in 2005 by a difference of 18.5% to 92.1%. But, the percentage of those who have a complete knowledge of the virus was higher in 2003 (58.8%) than 2005 (47.8%). This may be attributed to many factors; one of these is early misconception about HIV preventive measures most especially inability to differentiate between the various preventive methods in town. When people are not properly briefed, they may be carrying incomplete information about the demographic and health effects of the virus. Furthermore, the category of those who said that they were aware that sharing of sharp objects can lead to contraction of HIV was 52.2% in 2003 and increased to 76.0% in 2005. Whereas, the proportion of people who were aware that transfusion of unscreened blood can lead to transmission of HIV were less than other modes of HIV transmission. A female Programme Officer of an NGO in Sapele stated this about the knowledge of people about HIV and AIDS in the State:

> *When we talk about knowledge of HIV, it has different levels. Many people in the State have heard about HIV and its modes of transmission most especially the heterosexual contact mode of transmission. But significant number doesn't have complete knowledge about modes of HIV transmission. People still have misconception about the virus most especially in the rural areas where majority of people believe that witchcraft can cause HIV and they always attribute AIDS to the handy works of gods of the land. Thus, more efforts need to be put together to disseminate appropriate and complete information to the entire people of the State irrespective of their place of residence, educational level and the region where they live. A lot still needs to be done in this area in the State.*

Both quantitative and qualitative data from Delta State suggest lack of complete knowledge of modes of HIV transmission in the State. It is instructive to note that recent data on the distribution of HIV knowledge by gender show that men were aware of HIV more than women in 2008 in the State. The NDHS 2008 states specifically that majority of males constituting 94.6% compared with 89.6% females had knowledge of HIV in the State (NPC, 2009). One community leader in Udu corroborated this pattern during an in-depth interview. He stated thus:

> *Men are culturally the custodian of knowledge in this area and they are the leaders socially, politically and economically. Specifically, men look and search for knowledge in order to educate both their wives and children on any issues. Consequensely, their wives and children see men as their gods from whom they take directives. Even on temporary issues like HIV/AIDS men must be informed since they are the ones to instruct their dependants about the ways to avoid it.*

Table 3: Percentage distribution of respondents by knowledge of HIV/AIDS

HIV/AIDS Knowledge	Year	
	2003	**2005**
Have heard of AIDS	79.2	95.5
Know HIV is transmitted through sex	73.6	92.1
Have complete knowledge of HIV prevention	58.8	47.8
HIV is transmitted through sharing of sharp objects	55.2	76.0
HIV is transmitted through blood transfusion	67.2	68.8

Source: Federal Ministry of Health (2003, 2005b) National HIV/AIDS & Reproductive Health Survey

What this implies is that men were more enlightened about HIV pandemic than women in the State due to social expectations built on social hierarchy and stratification. It further implies that women are relatively more susceptible to HIV than men in the State.

Since it is not enough to be aware of HIV/AIDS, the essential thing is to know how to avoid the contraction of this virus among those who have not been infected and cross-infection among people living with HIV/AIDS. The 2008 NDHS report presents the knowledge of various preventive methods among men and women in the State. Specifically, men (66.8%) tend to know condom than women (48.3%) as a major means of preventing HIV transmission. Furthermore, more men (84.4%) knew that people can prevent HIV transmission by avoiding sexual promiscuity compared with 53.0% among women. When it comes to the combination of the two strategies, 63.0% of men compared with 40.5% of women mentioned the two preventive methods stated above. In addition, significant proportion of men (79.5%) mentioned abstinence from sexual intercourse compared with 55.2% that mentioned the same method among women (NPC, 2009).

HIV risk perception in Delta State

The perception of the people in Delta State of Nigeria on risk of contracting HIV varies from one LGA to another. It is important to note that an insignificant proportion of the people in the State felt to be at risk of contracting the virus between 2003 and 2007. Specifically, in 2003, it was 30.9%, it then dropped to 27.4% in 2005, while in 2007 it rose to 39.8%. Thus, perception among the residents of the State between year 2003 and 2007 had been divergent. The reason for this could partly be attributed to the fact that the region has been very busy for oil and gas businesses in the last two decades. As argued by a Programme Development Officer of an NGO in Warri:

> *The major problem we have is that majority of our people in the State do not perceive themselves to be at risk of HIV infection. Actually, they have heard of the virus,*

informed of its modes of transimmision but still perceive themselve not to be at risk of contracting the virus. This perception may lead to increase in transmission of HIV because perception has direct relationship with behaviour. Those people that perceive themselve to be at risk will make concious efforts to protect themselves, whereas those ones that do not perceive themselve to be at risk may engage in risky behaviour because they lack internal concouseness that they are at risk. I believe our intervention should be tailored to address this major gap between awareness and HIV risk perception of the people in the State.

Table 4: Percentage distribution of respondendents by HIV Risk perception

Year	Perceived to be at risk of HIV
2003	30.9
2005	27.4
2007	39.8

Source: Federal Ministry of Health (2003, 2005b, 2007) National HIV/AIDS & Reproductive Health Survey

It is instructive to note that the levels of HIV risk perception of people of this oil rich State were not encouraging since less than 40.0% of the people perceived themselves to be at risk of the virus irrespective of their sexual behaviours, and despite the observed increase in awareness programmes on the virus. In the next section, the article examines the practice of risk behaviour in the State.

3. Practice of Risk Behaviour

Three key variables were examined in this section by gender distribution of the sample population, these are having sexual intercourse with non-marital sexual partners, transactional sex and multiple non-marital partner in the last 12 months before various data collections. Data presented in Table 5 below on having sexual intercourse with non-marital sexual partners in the last 12 months indicate that from year 2003 to 2007, men that had non-marital sexual partners increased consistently from 34.2% in 2003 to 37.0% in 2005 and 39.2% in 2007. However, with the women, there was an initial increase from 20.9% in 2003 to 28.7% in 2005 and then a decrease to 21.5% in 2007. The practice of this risky behaviour and consistent increase of the behaviour among men will pose threat to various efforts put up to curb the spread of HIV and the virus may get to communities and neighbourhoods faster through men than women.

Table 5: Percentage distribution of respondents by practice of risk behaviour

Risk Behaviour	Year					
	2003		2005		2007	
	Men	Women	Men	Women	Men	Women
Having sexual intercourse with non-marital sexual partners in the last 12 months	34.2	20.9	37.0	28.7	39.2	21.5
Transactional sex in the last 12 months	11.4	5.3	14.6	12.1	14.4	10.4
Multiple non-marital partner in the last 12 months	13.1	2.6	14.4	5.0	13.2	2.6

Source: Federal Ministry of Health (2003, 2005b, 2007) National HIV/AIDS & Reproductive Health Survey

On the issue of transactional sex in the last 12 months, the percentage of men that were involved in this behaviour was slightly higher than that of women in the three years where data are available as presented in Table 5 above. In 2003, the percentage of men involved in transactional sex was 21.4% but this decreased to 14.6% in 2005 and further decreased to 14.4% in 2007. Also, the percentage of women involved in transactional sex was 15.3% in 2003, but by 2005 and 2007, it had decreased to 12.1% and 10.4% respectively. The implication of this finding is that over the years, men go into transactional or negotiated sex relationships more than women. Though this practice may be declining consistently over the years, the proportion of people engaging in this practice is still over 10.0%. This is dangerous in that person with whom sex is negotiated might not want to use HIV preventive methods. Hence, the overriding and dominant nature of men in sexual relationships might make more women to be susceptible to HIV infection.

The percentage of men and women having multiple non-marital sexual partners has also varied over the past three years under consideration. Principally, the percentage of women having multiple non-marital relationships was lower than that of men accross the years. Specifically, in 2003, 13.1% of man compared with 2.6% of women had multiple non-marital sexual partners. This differential was consistent in 2005 and 2007 respectively. This concurrent relationship is a major root of rapid transmission of HIV, most especially among people within the same sexual network and the general populace with similar socio-economic and ecological domain.

4. Use of Condom

Two essential issues about condom were investigated in this article. These are knowledge and ever use of condom based on National HIV/AIDS and Reproductive Health Surveys (NARHS) in Delta State in the year 2003 and 2005. Data on Table 6 below show that 66.0% of those interviewed in 2003 stated that they have heard of condom before as a protective contraceptive device that guides one against the contraction of HIV, while the proportion increased to 88.4% in 2005. But ironically only 40.8% of the respondents said they have ever used condom in their past sexual intercourse as at 2003; this proportion slightly increased to 41.6% in the year 2005. While the knowledge increased geometrically, the adoption and utilization of condom increased arithmetically. Elicited data from youth during the in-depth interview corroborate the gap between the knowledge and utilization of condom in the State. According to a male youth respondent at Sapele:

> *I know about the condom and I have seen it. I was told that it can prevent sexually transmitted infections such as gonorrhea and HIV. But personally, I don't like using it. It is not good and it can also give someone skin disease. A friend told me that the oil on it can cause itching and it used to break during sexual intercourse. I think the use of drugs for protection is better than the use of condom.*

Another female youth in Udu community retorted like this:

> *Condom we all know, but it use is always problematic. It hinders intimate relationship and also hampers sexual enjoyment. We have right to enjoy sexual relationship and most of our male partners normally complain that they don't enjoy sex with condom. Ladies can only insist on the use of condom when they don't know their sexual partners very well or when they don't trust them.*

Table 6: Percentage distribution of respondents by knowledge and use of condom

Condom Variable	2003	2005
Ever heard of condom	66.0	88.4
Ever used of condom	40.8	41.6

Source: Federal Ministry of Health (2003, 2005b) National HIV/AIDS & Reproductive Health Survey

The above data suggest the need to intensify efforts to make the use of condom very close to the knowledge most especially among sexually active members of the populace in Delta State. In the next section of the article, various socio-cultural practices and behaviour that may promote the transmission of HIV virus in the State were examined.

5. Socio-cultural Context of HIV/AIDS Pandemic In Delta State

In this section, salient and crucial socio-cultural factors that can promote rapid transmission of HIV in Delta State were identified and discussed. The basic knowledge of these context will assist programme planners and development agents to know various factors to put into their equations during modeling of intervention programmes that will reduce HIV transmission and also ameliorate the impact of the virus in the State. These variables are examined below:

Patriarchy and polygyny

The high level of vulnerability of women and young girls to the problem of HIV in contemporary Nigerian society is not unconnected with the patriachal nature of gender relations and structure in the country. In all societies in Nigeria, culture allows men to dominate in all family decisions including reproductive behaviour, and in extension responsibilities. Consequently, most men see women as being under their control and men inherently have conjugal ownership. In some cultures, women are seen as the property of the men, and so whatever instructions coming down from the community leaders or heads of households who are apparently men must be admitted by women unquestionably; this also obtainable in Delta State. The coming of colonial rule and industrial capitalism from the West allowed men to dominate the emergent money market economy. Women, that traditionally had a place in the marketing of farm produce became increasingly alienated by the capitalist sexual division of labour, which separated what men can do from what women can do. The growth of industries and government functionaries followed this pattern. Gradually, women lost almost all their traditional roles to European capitalism that encouraged patriarchy.

Today, most women, who want to make it have to rely on available norms and values of the money-market economy which says that anybody aspiring to grow must respect the management. The question is who are the members of this management? Apparently they are men. Women in formal labour force face different types of discrimination which often times make those in the lower and middle cadre of their career susceptible to sexual harrassment. (Olurode and Oyefara, 2010). Exposure to unpredictable sex partinership may trigger off or cause the escalation of HIV transmission among these categories of women in particular, and among the entire members of the society in general.

In the informal sector, women and young girls burden is further worsened by inability to have good education and basic needs of life. Thus, in order to remain in their community and among friends, they have to use what they have (**sex organ**) to get what they don't have (**money**). Increasing and mass rush of oil multinationals to the Niger Delta of the country makes customers readily available for these category of sex workers (whether brothel or non-brothel based). Patriarchy has therefore been identified as a major factor affecting the negotiating powers of women in Nigeria at large and Delta State in particular (Abu, 2004). Most significant in this regard is the weak economic power of most women. The implication of this, is that weak economic power lowers their negotiating power in sexual relationships. No wonder, most susceptible women to HIV often fall among the poor population. Various responses during in-depth interview in different communities in the State support this assertion. As stated by an adult woman in Ughelli community:

> *We women in this community are not socially recognised as the leaders or heads. Leadership and headship belong to men. Men own everything including economic, social and political power in our land. For example, they are the owner of land the major source of economic strenght in the State. For women to use the land here, we*

need to take permission from men and we do pay them royalties for the use of the land we cultivated. This is actually, the men's world.

Another young woman in Isoko community stated that:

In marriage and all other issues relating to family, men are the decision makers. They determine when women should have sexual intercourse and be pregnant, the number of children we should have, the kind of antenatal care facility to be used, the child spacing interval and all issues relating to reproduction. In addition, men do have all economic power. A man has unlimited sexual freedom, both in and out of marriage, while a woman is expected to stick to one partner at a time. Thus, a man can be the husband of several wives, but the woman is a wife to only one man. Within this milieu it is extremely difficult for women to negotiate for safe sex, you can neither insist on the use of condom with your spouse nor prevent him from having extra-marital affairs outside home. Women are really handicapped in patriarchal societies like ours. There is a need for women organizations and government at all levels to put in place all necessary mechanisms to protect women in Delta State.

The responses and above observations indicate that patriarchy and polygyny (a system of marriage in which a man marries more than one wife) are part of the driving forces of HIV transmission in Delta State.

High belief in Traditional Birth Attendants (TBAs) and Traditional healing homes with high level of scarification as a treatment procedure

Considering the nature of sub-Saharan Africa societies, and its level of civilization, most people still have strong beliefs in the powers of the unseen gods in the treatment of diseases. It is not uncommon in Delta State to find people patronizing TBAs for sacrificial cleansing, hoping that, that will culminate into the eradication of misfortunes and spiritual attacks. Even urban dwellers still patronize herbalists who may even have big apartments where they attend to their clients. Health-seeking behaviour is influenced by the perception of the cause of illness in the community or communities. If most people believe that a particular kind of disease cannot be cured by the orthodox medicine, the tendency is to have more people drifting towards traditional or religious health attendants.

One community leader in Ndokwa town stated that:

Our fore fathers have a way of healing and treating various ailments before the advent of orthodox medicine. We still believe in traditional medicine because modern medicine cannot cure all diseases, but our ancestors and gods normally heal all ailments we brought to them. Although the process normally requires sacrifice and possibly scarification of various forms, these are effective and efficient means of healing in our land in relation to orthodox medicine.

The health-seeking behavior of people in Delta State, most especially their belief in TBAs and process of scarification necessitate the sharing of sharp objects and this may increase the transmission of HIV in the State.

Widow inheritance is still in practice

The practice of inheriting wives of one's late brother is still prevalent in Delta State, most especially in the rural areas. And in as much as this practice continues, it may be difficult to avoid the spread of HIV among the people who still maintain such cultural parctice. Widowhood practices do not only subject women to inhuman treatment, women become subjects and property of those that have inherited them as wives. Wife inheritance still in practice in rural areas is a potential source for escalation of HIV. One widow in a village in Uvwie community explained the inhuman condition widows normally pass through during the process of widowhood rites in their community and how these practices may aid HIV transmission:

The demise of one's spouse is already a great loss and sorrow for a woman, the most sympathetic issue is the series of widowhood rites a woman must observe immediately the husband dies. These ranges from confinement, proof of innocence, disinheritance and widow inheritance among other things. Women in this community have no choice than to be inherited by the brothers of their late husbands' if they want to be part of that lineage and have access to other properties of their late husbands.

The cultural practice of widow inheritance within the context of HIV predisposes either the widow or the brother who is to inherit the woman to the contraction of the virus in a situation when any one of them had contracted HIV.

Female circumcision is still on-going in Delta State despite legislation

Female circumcision is another deadly cultural practice promoting the spread of HIV in Delta State. The high prevalence of this practice in the State led to the legislation against female circumcission by the State House of Assembly with severe fines and punishments for any parent caught subjecting his/her daughter to circumssion. Despite the legislation, the practice is still on-going in the State. One old woman in Oshimili community explicated the various reasons being adduced to continue the practice of female circumsision in Delta State, most especially in the rural areas and among the illiterates in the State:

Female circumcision is an old cultural practice in our communities. I was circumcised when I was young; alas I am still alive with full energy at my 75 years birthday. If you don't circumcise your daughter there is no way she can be a good woman in the future. Our culture is totally and completely against ladies that are not circumcised. She will not be able to fulfill the expected roles and responsibilities of womanhood either to her immediate family or to the larger society. Uncircumcised women are more likely to be promiscuous and possibly infertile. Circumcision inhibits unnecessary sexual urge towards opposite sex who is not your spouse and you will invariably be a woman of honour with full respect from entire members of your community. Although recently they said the government has made law against it, but we still circumcise our daughters and our children in Lagos and other cities abroad normally bring their daughters home for circumcision.

It is instructive to note that females who went through circumcision are more likely to contract HIV because of the sharing of unsterilized knives normally utilized by local circumcisors for many children at the same time.

Growth of junction towns for long distance tanker drivers and high number of brothels

The establishment of junction towns for long tanker drivers also promote the spread of HIV in Delta State, Nigeria. Tanker drivers always see these towns as places where they could relax and enjoy. Young girls are usually attracted by the large pool of tanker drivers in these towns. Not only that, these drivers are usually ready to spend their last kobo to attract beautiful ladies who are ususally unconscious of the danger of this casual sex relationships, in most cases there are many sex workers soliciting for business in these towns. Thus, there is proliferation of brothels and commercial sex workers in most of these junction towns which invariably fuel the spread of HIV infection in the State. The increasing number of brothels is adding to the aggravation of transmission of HIV among the populations housing these brothels. The virus usually begins and rapidly multiplies where brothels are located and then spreads to other neigbouring communities around the place. In particular, the issue of sex hubs abound around the oil flow stations and major cities like Sapele, Warri and Asaba the State capital.

6. State Response and Response Gap Identification

This section looks at the various efforts of governements at all levels as well as that of local and international agencies in reducing the transmission of HIV and mitigating the impact of the problem of HIV/AIDS in the State.

Structure and Functionality of the Structure

In response to HIV/AIDS pandemic in Delta State, the following structures are currently in place. These structures are: Delta State Action Committee on AIDS (SACA), State AIDS/STDs Control Programme (SASCP), and Local Government Action Committee on AIDS (LACA) in all 25 LGAs in the State. The main objectives of these structures are to prevent, mitigate and ameliorate the impact of HIV/AIDS in the State.

It is essential to know the functionality of each of the structures mentioned above. A critical assessment of the three arms revealed the following as explained by Programme Director of DELSACA in the State during in-depth interview sessions:

> *DELSACA is highly functional in the State. Specifically, it has a 15 board members Committee. SASCP is also functional and it is located in the State Ministry of Health. It is imperative to note that not all the LACAs in the State are functional. Specifically, only five are functional and had accessed funds from DELSACA for now. Poor funding is the major reason behind poor performance of LACAs in the State. It is imperative to note that political commitment varies according to the administrative base of each of these structures. SACA and SASCP are based at State level, while LACA is based at local government level. There is high political will at the State level, but no political will at the LGA level in the State.*

The weak operation of LACA, poor funding and relatively lack of political will to fight HIV/AIDS at the LGA level suggest potential for escaltion of HIV/AIDS at local level in the State. This is because in the political structure of Nigeria, LGA is the grassroot and closest arm of government to the community people.

Availability of policies, Development Partners and Service Delivery Points

The Programme Director of DELSACA explained further that the following HIV/AIDS policies are available and already adopted in the State:

> *Presently in the State, DELSACA works with the National HIV/AIDS policy, National OVC policy, Workplace policy, Child right law in the State, Law criminalizing Female Genital Mutilation, Free maternal services for pregnant women in Government facilities, Free air time for airing HIV/AIDS activities in the State media own houses. In addition,ART, PMTCT, HCT, NNRIMS guidelines are also available with State strategic plan 2008-2011. The new State Strategic plan on HIV/AIDS for 2010 – 2015 has also been developed. In addition, line ministries action plans are also available.*

In the area of international Development Partners and National organisations working in the State, he explained that:

> *Presently, we have 76 registered Civil Society Organisations or NGOs working on HIV/AIDS in the State. Most of the CSOs/NGOS work in the areas of HIV prevention, Treatment, Care and Support. In addition, we have about thirteen international development partners working in the State. These CSOs/NGOs and international*

development partners are working in the State, but their activities are skewed toward urban areas which is detrimental to rural dwellers in the State. Apart from high concentration of the programmes in urban areas, the number of available CSOs/NGOs and international development organizations working in the areas of HIV/AIDS in the State is grossly inadequate compared with the enormity of the required jobs to be done in order to stem and sustain the reversal of the pandemic in the State.

This response suggest potential for escalation of the virus most especially in the unreached rural areas of the State. Data on Table 7 below also revealed the type and number of service delivery points in the State by location. It is important to also note that most of the service delivery points in the state were located in urban areas as at 2011.

Table 7: Nature and total number of service delivery points by location in Delta State

Nature of service	Total	Location (Rural/Urban)	Number by International Partners (IPs)
HCT	25	20 Urban, 5 Rural	13
PMTCT	11	10 Urban, 1 Rural	11
ART	9	8 Urban, 1 Rural	9
HIV/TB	9	8 Urban, 1 Rural	9

Source: Delta State Action Committee on AIDS (DELSACA), 2011

One of the officers of of the Association of People living with HIV/AIDS in the State explained the various challenges of PLWHA with regards to available services:

The major problem of PLWHA in the State is about access to treatment. The service delivery points are majorly located in the urban centers and our members in the rural areas do have problem of accesing treatment. The few Support Groups we have are also greatly located in the urban areas and the Home Based Care services for those ones that are very sick are relatively not in existence in the State. Indeed, the PLWHA in Delta State need supports in order to get required treatments in rural areas and at home level.

Funding and Funding gaps on HIV/AIDS in Delta State

The Programme Director of DELSACA provided the following information about the funding and funding gaps on HIV/AIDS programmes and activities in Delta State:

There are three major sources of funds in the State to implement various HIV/AIDS intervention projects. These sources are: The State Government, World Bank, and Development Partners. As stated earlier, there is high political will and great commitment at the State level. This is demostrated at the level of budgetary allocation and release by the State Government. For instance, in 2008, a total of Thirty-eight million, Eight hundred and eighty-six thousand, Four hundred and Fifty-three naira, and Sixty-one kobo (N38,886,453.61K) constituting about 95% of the budgetary allocation in the year was released and spent. In 2009, a total of One hundred million (N100,000,000) was budgeted out of which Sixty million (N60,000,000) constituting about 60% was released and spent. It is imperative to note that data on funding from development partners are not available.

He explained further:

Despite the stated high political will and great commitment at the State level, there are some funding gaps in the State. These are: 1) late release of fund due to unnecessary bureaucratic impediments and bottlenecks. This, invariably hinders

quick response and timely implementation of various programmes and projects. 2) There is factually no political will and commitment at local government level across the State. Consequently, LACAs in the state lack funds to implement their various activities. LACAs are 100% DELSACA dependent, unfortunately DELSACA to a certain extent is donor dependent and may not be able to give the needed support to LACAs on their various activities and programmes.

These findings suggest the need to improve the funding and appropriate strategies to close the funding gaps in the State.

Monitoring and Evaluation (M&E)

Monitoring and Evaluation strategy of the State was also examined. The M&E officer of DELSACA explained that:

In DELSACA, M&E work plan is available, and we normally have regular State M&E meetings with partners. In addition, the Nigeria National Response Information Management Sysytem (NNRIMS) is operational in the State. We are tracking all the indicators and regularly submit our report to National Agency for the Control of HIV/AIDS (NACA). The major problem we have in the State is inability to track the activites of CSOs/NGOs. Many of them do not provide regular reports as expected on monthly basis even among those ones that have registered with DELSACA.

This response suggest the need to update and re-designed the M&E structure in the State in order to capture all HIV/AIDS activities in the State and to have holistic view of the pandemic in the State.

Discussion of Findings, Potential for Escalation and Recommendations

One of the major findings of this composite analysis of social dynamics of HIV/AIDS epidemiology in Delta State is that the prevalence rate of HIV has been very stable since 2005 which shows some degrees of progress already made by Delta State Government and the international coomunity. The prevalence rate has also varied across geographical spaces - in fact reports on rural-urban differences show that urban communities recorded high level of new HIV cases than the rural areas. The findings also show that the local government with the lowest case of HIV was Warri-South Local government (0.24%) as at 2011, while the one with the highest HIV prevalence was Ukwani (6.7%). This wide gap between Warri-South and Ukwani Local Government signals that a lot of jobs still need to be done. There is potential for escalation of the virus unless funds are made available and activities are developed and implemented to change the present soci-cultural practices that make many people vulnerable to the pandemic most especially in the rural areas.

HIV/AIDS awareness is however, higher among the male population than the female population 94.6% to 89.0%. Of these gender groups, men were more knowledgeable than women in terms of limiting sexual intercourse with one non-infected partner including use of condom and abstinence from sexual intercourse. This suggests that much still needs to be done on women sensitization towards HIV prevention strategies. As regards the issue of risk perception of people in the State, one could infer from the data that about 60.0% did perceive themselve to be at risk. In addition, over the years, more men have been taking the lead in having non-marital concurrent and transactional sexual partners than women, and this trend has continued over the years (2003, 2005 and 2007). This behaviour suggests potential for dangerous escalation of the HIV pandemic in both rural and urban areas considering the increase in rural-urban migration in the State.

There is also a potential danger for escalation of HIV transmission, considering the low usage of condom among sexually active members in the State. Available data suggest that HIV awareness is waning in the urban areas following un-sustained HIV campaigns emanating from poor funding. There is however, fear of escalation of HIV transmission in the rural areas following the invasion of soldiers

during the recent militants, oil companies and government face-off. Most pathetic is a situation whereby the youth and those in their active reproductive ages 15-24 become more susceptible to the pandemic as a result of kidnapping and attendant rape.

There is a need to improve on the number of service delivery points of ART, PMTCT, HCT and HIV/TB in the State most especially in the rural areas. The service delivery point should be established very close to PLWHA. The number of CSOs/NGOs and international agencies working in the State needs to be increased. DELSACA should develop approriate mechanisms and create condusive environment that will attract more donor agencies to the State and lead to the establishment of new local CSOs/NGOs working in the areas of HIV/AIDS.

There is also need for advocacy visits to the Executives and State House of Assembly for the initiation and enactment of approriate legislations that will eradictate most of the socio-cultural practices identified to be inimical to the well-being of the people in the State. Relevant law enforcemrnt agencies and government parastatals responsible for the implementation of the laws should be sensitized on the needs to enforce various laws that will reduce the spread of HIV in the State. These recommendations if properly considered and implemented will invariably counter all the potentials for escalation of the virus in the State.

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