

**SOCIO-CULTURAL FACTORS INFLUENCING THE PREVALENCE OF HUMAN
IMMUNODEFICIENCY VIRUS (HIV) IN ASA LOCAL GOVERNMENT AREA, KWARA STATE,
NIGERIA**

BY

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Abstract

This study investigated the Socio-cultural Factors Influencing the Prevalence of HIV in Asa Local Government Area, Kwara State, Nigeria. Respondents were individuals aged 18 years and above who are residents for at least six months, Data were collected using a structured questionnaire. 400 sample size was determined using Fisher's formula. Multi-stage sampling technique was used to select participants, and collected data were analysed with SPSS version 26. The study revealed (100%) awareness of HIV among respondents, yet knowledge accuracy varied, with significant misconceptions about transmission persisting. A significant relationship was found between age and HIV knowledge ($\chi^2 = 8.409$, $p = 0.015$), with younger respondents (≤ 30 years) having a higher percentage of good knowledge (67.0%). Gender also showed a significant association with HIV knowledge ($\chi^2 = 10.911$, $p = 0.001$). As education level was also strongly associated with HIV knowledge ($\chi^2 = 190.265$, $p = 0.001$). These findings revealed the importance of socio-demographic factors in influencing knowledge about HIV. Behavioral changes, such as reducing sexual partners and using condoms, were reported by 82% of respondents, but risky behaviors continued, influenced by socio-cultural factors like polygamy, reliance on traditional healers, and gender norms. Cultural practices were identified by 89.3% of respondents as contributing to HIV prevalence, particularly through polygamy and traditional rituals involving unsterilized practices. It was concluded that there are misconceptions about HIV that stems from cultural beliefs that negatively influences HIV prevention and care. It is essential to implement interventions that are culturally sensitive and tailored to the community's unique social dynamics.

Introduction

HIV infection has spread over years since the beginning of the epidemic and has posed a significant impact on health, welfare, employment and criminal justice sectors; affecting all social and ethnic groups throughout the globe. Epidemiological data have indicated that HIV remains a global public health issue that persistently drains our economic sector having claimed about 40.4 million [32.9–51.3 million] lives so far with an ongoing transmission globally (WHO Fact Sheet, 2023). By the end of 2022, the estimated overall number of People Living with HIV (PLWHIV) worldwide was approximately 39.0 million [33.1–45.7 million], with Sub-Saharan Africa being the most affected region, having 25.6 (24.0–28.7) million of PLWHIV, that is, nearly 1 in every 25 adults (3.2%) living with HIV, thus, accounting for more than two-thirds of the people living with HIV worldwide. The first two AIDS cases in Nigeria was diagnosed in 1985 and reported in 1986 in Lagos, one of which was a young female sex worker aged 13 years from one of the West African countries (Nasidi & Harry, 2006). Caldwell et al. (1992) claim that the early under reaction to AIDS was caused by the syncretic aspect of African religion, which holds that events are multicausal and that death is predestined in timing. This fatalistic attitude allowed some people to remain in denial about the epidemic. However, People's actions when seeking medical attention and taking precautions to avoid infection are ultimately influenced by their beliefs regarding the cause of diseases. Many Nigerians think that illnesses have more complicated roots than what contemporary medicine suggests.

The complexity of the HIV/AIDS epidemic stems from its links with all aspects of society and culture. (Smith et al., 2002). In addition to having an impact on the effectiveness of preventative measures and the level of compassion

shown to infected individuals, social and cultural factors also have a significant impact on the viral transmission. Culture is one of many factors influencing human behavior; it is a determinant of socially accepted behavior, value systems, beliefs, and practical knowledge. Culture is deeply rooted in all aspects of a society, including local perceptions of health and illness and health seeking behaviors. However, culture in the broader sense, includes also traditions and local practices, taboos, religious affiliations, gender roles, marriage and kinship patterns, and so forth. (Körner, 2007). The activities through which society defines and identifies itself are unique but many and vary from society to society. These activities manifest themselves through values norms beliefs and practices which may have positive and negative implication for the wellbeing or otherwise of the population. Most of these cultural norms and practices are related to human sexuality while others are related to day to day activities or practices of the society. (Maxim et al., 2011). Some of these cultural norms and practices relating to sexuality contribute to the risk of HIV infection. Some of these practices include but are not limited to early marriage, polygamy, multiple and concurrent sex partners, delivery outside the health facility without a skilled birth attendant, female genital mutilation, unsterile traditional bloodletting and traditional marking and tattooing, among others.

In Nigeria, HIV prevalence clearly varies by states. While HIV/AIDS tends to be generally low in most parts of the country, the highest numbers of HIV prevalence were found mostly in Benue, FCT, Anambra, Bayelsa and Akwa Ibom States of the federation. These marked differences in the prevalence rates among these states could be due to a number of factors including but not limited to cultural differences, varying levels of education, religion and differing socioeconomic structures. Indeed, there must be interplay of these factors on HIV/AIDS outcomes in these states. The variations in socio-cultural and religious practices among about 400 different ethnic groups in Nigeria have implications on the risk of HIV transmission. Notably, some practices that include multiple and concurrent sex partners, delivery outside the health facility without a skilled birth attendant, female genital mutilation, unsterile traditional bloodletting and traditional marking and tattooing will lead to an increase in the risk of HIV transmission (Nigeria National Agency for the Control of AIDS, 2010). According to Adeokun (2006), in Nigeria, about 95% of HIV infections are due to heterosexual transmission, where having multiple sexual partners has been a major behavioral element fuelling the epidemic. However, there is also a close relationship between culture and other routes of transmission. Mother-to-child transmission of HIV is an inevitable aspect of the unfolding epidemic due to high fertility choices, heightened female infection rates, and low levels of voluntary counseling and testing (VCT). Also, significant portions of the impoverished urban and rural populations are exposed to unscreened blood due to the uneven distribution of HIV screening programs. Additionally, a sizable number of people are at risk of infection via nonsexual traditional practices, particularly the male and female circumcision, and the custom of creating facial and body markings with shared, non-sterile skin-piercing tools. (Okochi et al., 2000).

However, in addressing this socio-cultural and economic divide; The Joint United Nations Program on HIV/AIDS emphasized the need to address the socio-cultural behaviours and values of communities that expose individuals to HIV risk behaviours. This approach is believed would lead to effective HIV/AIDS intervention strategies (UNAIDS, 2006). Furthermore, UNAIDS (2002) noted that sexual behaviour is the most important factor influencing the spread of HIV in Africa, Nigeria in particular and that behaviour varies greatly across cultures, age groups, socio-economic class and gender. Nigeria ranks third among countries with highest burden of HIV infection in the world, reporting over 1.9million people living with HIV, 1.3% of which are adult, with over 74,000 of new reported cases, and 51,000 AIDS-related deaths. (WHO Fact Sheet, 2023). According to a recent community diagnosis carried out in some parts of Asa Local Government Area of Kwara state by the Clinical Care and Clinical Research, Nigeria (CCCRN), a Non-Governmental Organization, it was observed that at least 4 of every 10 people (40%) screened for HIV in these communities are reactive i.e. tested positive to having contracted the virus. These figures are much higher than the 2.2% prevalence rate among the general population of Kwara state reported by Ahmed et al., (2021), and also much more higher than that of the Kwara State AIDS Control Agency's (Kwasaca) claim in 2023, that the state has a prevalence of 1%. Hence, this poses a great threat to public health and the overall wellbeing of the people within and outside these communities, and the urgent need for a study to understanding the socio-cultural dynamics that may have influenced HIV prevalence in these LGA differently compared to other parts of the state

Objectives

- i. To assess the level of awareness and knowledge about HIV among the residents of Asa LGA, Kwara state.
- ii. To identify cultural beliefs and practices related to HIV transmission and prevention within Asa LGA, Kwara state.
- iii. To examine the impact of socio-cultural norms on HIV testing, treatment and care-seeking behaviour in Asa LGA, Kwara state.
- iv. To recommend culturally appropriate interventions and strategies for mitigating the prevalence of HIV in Asa LGA, Kwara state.

Research Questions

- i. What are the predominant socio-cultural practices in Asa LGA that influence the spread of HIV?
- ii. Do residents of Asa LGA, Kwara state have adequate knowledge on HIV?
- iii. How does the level of awareness and knowledge about HIV in Asa LGA affect its prevalence?
- iv. What role do gender norms and relations play in the transmission of HIV in Asa LGA?
- v. How do religious beliefs and practices impact HIV prevention and treatment in Asa LGA?
- vi. How effective are local health interventions and policies in addressing socio-cultural factors related to HIV in Asa LGA?

Research Hypothesis

H₀₁: There is no significant difference in the level of awareness and knowledge about HIV and prevalence of HIV among the residents of Asa LGA, Kwara State.

H₀₂: There is no significant association with Cultural beliefs and practices in Asa LGA, Kwara State, with HIV transmission and prevention.

Methodology

This study was conducted in Asa LGA of Kwara State using a descriptive cross-sectional study design and a quantitative data collection method. The target population comprised residents aged 18 and above who had lived in Asa LGA for at least six months. Participants provided informed consent. Residents living in the area for less than six months or those under 18 were excluded. The sample size was calculated using Fisher's formula, considering a 95% confidence level, a 65.6% HIV transmission awareness proportion from a previous study, and a 0.05 degree of accuracy. This yielded a sample size of 347, which was increased to 385 to account for non-response, and finally to 400 to enhance statistical power. A multi-stage sampling technique was used. Five out of 17 wards were randomly selected. From each selected ward, one community was chosen by balloting. Within each community, the first house was selected using a grid method, followed by proportionate allocation of questionnaires based on community population size. In households with multiple eligible respondents, one was selected by simple random sampling.

A pre-tested, semi-structured, interviewer-administered questionnaire was used. The instrument's validity was assessed by research methodology experts and the supervisor. A pre-test was conducted with 40 residents in Gaa-Akanbi, Ilorin South LGA, and necessary revisions were made. Four trained research assistants collected data over four weeks. The questionnaire covered socio-demographics, HIV awareness and knowledge, cultural beliefs and practices related to HIV, the impact of socio-cultural norms on HIV-related behaviors, and culturally appropriate interventions. Data was analyzed using SPSS version 26.0. Chi-square tests and logistic regression were used to assess associations and identify independent factors influencing HIV prevalence. Knowledge levels were categorized as good (6-12 score) or poor (0-5 score). Ethical approval was obtained from Al-Hikmah University's Ethical Review Committee. Informed consent was obtained from participants, and anonymity and confidentiality were maintained. A limitation of the study was the potential for non-disclosure of information by residents.

Results

Sociodemographic Characteristics

The majority of the respondents were aged 30 years or younger (52.3%), with a smaller representation from those aged 31–40 years (29.3%) and those older than 40 years (18.5%). In terms of gender, females constituted a larger portion of the sample (60.5%) compared to males (39.5%). Ethnic distribution indicated that the Yoruba tribe was predominant (70.0%), followed by other ethnic groups such as the Igbo (8.5%) and Hausa (7.0%), with the remaining respondents (14.5%) belonging to various other ethnicities. The religious affiliation of respondents showed that Islam was the most practiced religion (73.3%), while Christianity was followed by 26.8% of the respondents. Regarding educational attainment, a significant proportion of the respondents had completed secondary education (45.3%), with tertiary education (32.5%) also well represented. A smaller percentage of respondents reported having primary education (9.3%), no formal education (6.5%), or other types of educational backgrounds (6.5%). Income levels varied, with the majority of respondents earning between 10,001 and 50,000 Naira (53.0%). A smaller proportion earned less than 10,000 Naira (19.0%), while 28.0% reported earning more than 50,000 Naira.

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency	Percentage
Age groups		
≤ 30	209	52.3
31 – 40	117	29.3
> 40	74	18.5
Gender		
Male	158	39.5
Female	242	60.5
Tribe		
Yoruba	280	70.0
Hausa	28	7.0
Igbo	34	8.5
Others	58	14.5
Religion		
Islam	293	73.3
Christianity	107	26.8
Level of education		
None	26	6.5
Primary	37	9.3
Secondary	181	45.3
Tertiary	130	32.5
Others	26	6.5
Income		
≤ 10,000	76	19.0
10,001 – 50,000	212	53.0
> 50,000	112	28.0

Respondents Occupation

Figure 1 revealed that about 36.0% of the respondents have their own personal business, 38.8% and 17.5% of the respondents were artisans and civil servants respectively while 7.8% were housewives

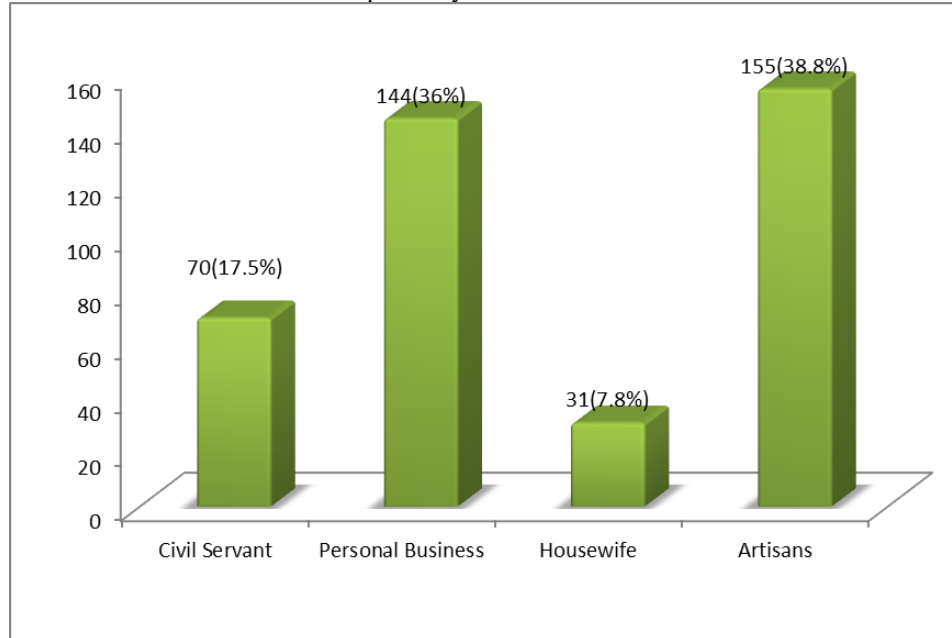


Figure 1: Presentation of respondents by occupation

Awareness and knowledge about HIV among the residents

All respondents (100.0%) reported having heard of HIV. The primary sources of information included the internet (41.5%), health workers (28.5%), and radio/TV (21.0%), with a smaller portion receiving information from religious leaders (9.0%). When asked to define HIV, 61.0% correctly identified it as Human Immunodeficiency Virus. However, a significant number of respondents provided incorrect definitions, with 30.0% referring to it as Human Infection Virus and 9.0% as Human Immunization Virus.

Table 2: Awareness and knowledge about HIV among the residents

Variables	Frequency	Percentage
Heard of HIV		
Yes	400	100.0
No	0	0.0
Sources of information		
Health workers	114	28.5
Radio/TV	84	21.0
Internet	166	41.5
Religious leaders	36	9.0
Definition of HIV by respondents		
Human immunodeficiency Virus	244	61.0
Human infection Virus	120	30.0
Human Immunization Virus	36	9.0

Means of transmission of HIV

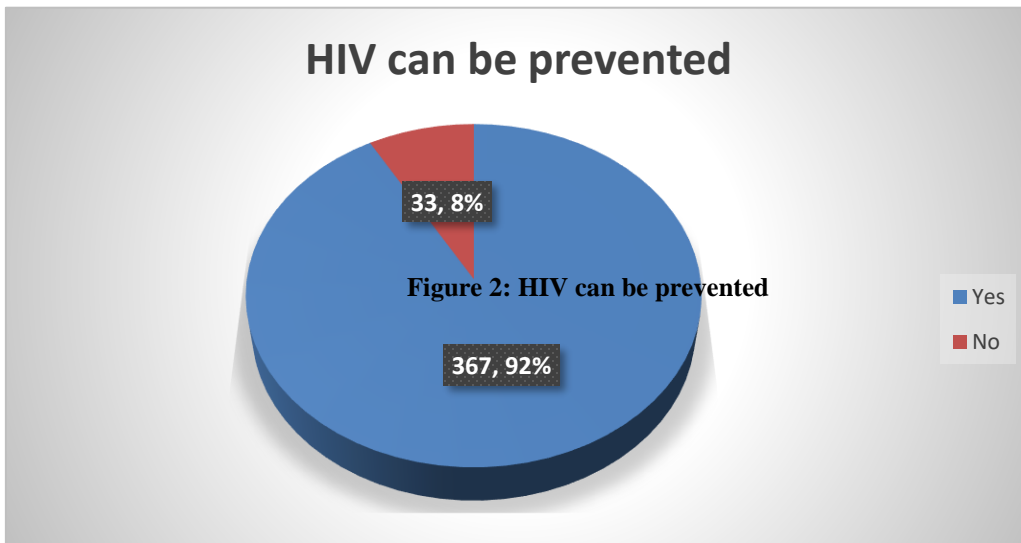
Majority of the respondents correctly identified unprotected sex (89.3%) and blood tests (98.5%) as means of transmission. More than half also recognized mother-to-child transmission at birth (60.8%) and sharing of needles (54.3%) as potential transmission routes. However, there were misconceptions among some respondents. A notable percentage incorrectly believed that HIV could be transmitted through mosquito bites (17.2%), sharing utensils (11.5%), kissing (10.3%), or using the same toilet (10.8%).

Table 3: Means of transmission of HIV

Variables	Yes (%)	No (%)
Unprotected sex	357 (89.3)	43 (10.7)
Sharing of needles	217 (54.3)	183 (45.7)
Mother to child at birth	243 (60.8)	157 (39.2)
Mosquito bites	69 (17.2)	331 (82.8)
Sharing of doo utensil	46 (11.5)	354 (88.5)
Through kissing	41 (10.3)	359 (89.7)
Sharing of toilet	43 (10.8)	357 (89.2)
Through blood test	394 (98.5)	6 (1.5)

Knowledge about Prevention of HIV

Figure 2 revealed that most of the respondents identified that HIV can be prevented while 8.0% believed that it cannot be prevented.



Way of HIV prevention

A high percentage identified having fewer sexual partners (91.0%), taking antiretroviral therapy (ART) (91.0%), using sterile needles (90.5%), and abstinence (82.0%) as effective preventive measures. Additionally, 81.5% believed that increased knowledge could reduce HIV transmission, while 68.8% acknowledged the use of condoms

as a preventive measure. However, some gaps in knowledge were noted, as 31.0% did not recognize ART as a preventive measure, and only 9.0% acknowledged male circumcision as a method of prevention. Awareness programs in the community were also recognized by 61.8% of the respondents as important in preventing HIV.

Table 4: Ways of prevention of HIV

Variables	Yes (%)	No (%)
ART	276 (69.0)	124 (31.0)
Use of condom	275 (68.8)	125 (31.2)
Fewer sex partner	364 (91.0)	36 (9.0)
Taking ART	364 (91.0)	36 (9.0)
Male circumcision	36 (9.0)	364 (91.0)
Using sterile needles	362 (90.5)	38 (9.5)
Abstinence	328 (82.0)	72 (18.0)
Awareness programmes in the community	247 (61.8)	153 (38.2)
More knowledge reduces HIV	326 (81.5)	74 (18.5)

Frequency of HIV information sharing in the community

Only 12.0% of the respondents noted that they frequently share HIV information in their community, 40.0% noted that they occasionally spread HIV information in their community while 3.0% of the respondents noted that they never share HIV information in their community.

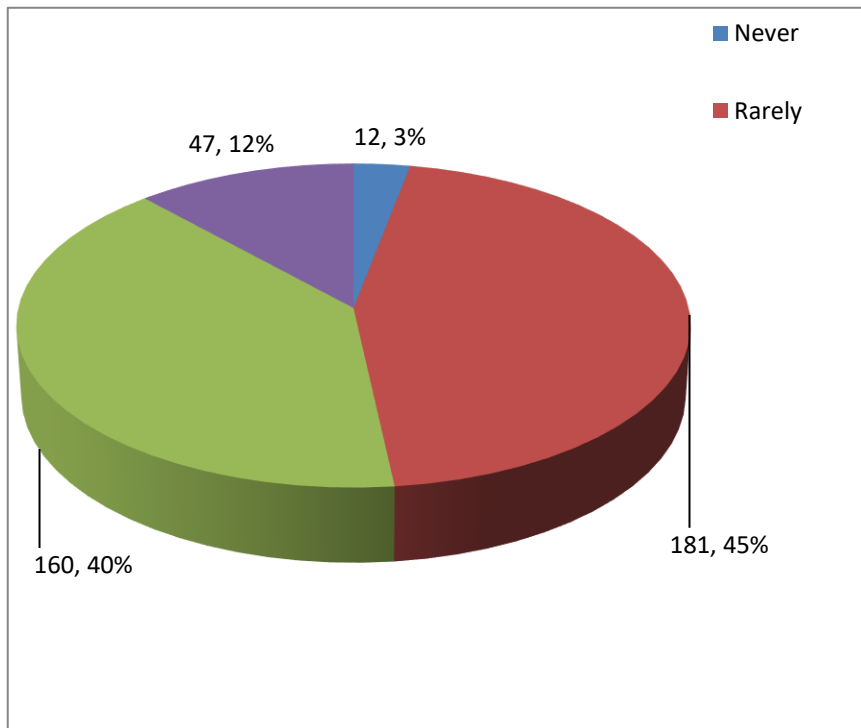


Figure 3: Frequency of HIV information sharing in the community

Cultural beliefs and practices related to HIV transmission and prevention

A significant majority of respondents (82.0%) reported changing their behavior after learning about HIV. Among those who made changes, 40.5% reduced the number of sexual partners, 35.1% got tested for HIV, and 24.4% started using condoms. Common practices within the community included polygamy (51.2%), traditional healing practices (30.5%), and gender inequality (18.3%). These practices were also perceived as contributing to HIV transmission, with traditional healing practices (48.5%) and polygamy (42.0%) being the most frequently cited. Regarding gender norms, 91.5% of respondents believed these norms influenced HIV transmission, particularly through men having multiple sexual partners (50.3%) and women's inability to negotiate safe sex (26.0%). Stigma against women living with HIV was noted by 23.7% of the respondents. Finally, 71.5% of respondents acknowledged that belief systems and religion influence HIV, with promoting abstinence (42.3%), providing care and support for people living with HIV (40.9%), and opposing condom use (16.8%) being the main ways these influences manifest.

Table 5: Cultural beliefs and practices related to HIV transmission and prevention

Variables	Frequency	Percentage
Change behavior after learning		
Yes	328	82.0
No	72	18.0
Types of changes in behavior	n=328	
Started using condom	80	24.4
Reduced number of sexual partner	133	40.5
Got tested for HIV	115	35.1
Common practices in the community		
Polygamy	205	51.2
Traditional healing practices	122	30.5
Gender inequality	73	18.3
Believes and Cultural practices that contribute to HIV	n=357	
Polygamy	150	42.0
Traditional healing practices	173	48.5
Gender inequality	34	9.5
Gender norms influences HIV		
Yes	366	91.5
No	34	8.5
Gender norms that influences HIV		
Men having multiple sexual partners	184	50.3
Women inability to negotiate safe sex	95	26.0
Stigma against women living with HIV	87	23.7
Believe system and Religion influences HIV		
Yes	286	71.5
No	114	28.5
Ways by which believe system and Religion influences HIV	n=286	
Promoting abstinence	121	42.3
Opposing condom use	48	16.8
Providing care and support for people living with HIV	117	40.9

Believed cultural practices that contributes to HIV

Most of the respondents (89.3%) believed that cultural practices contributed to HIV while 10.7% noted that cultural practices did not contribute to HIV.

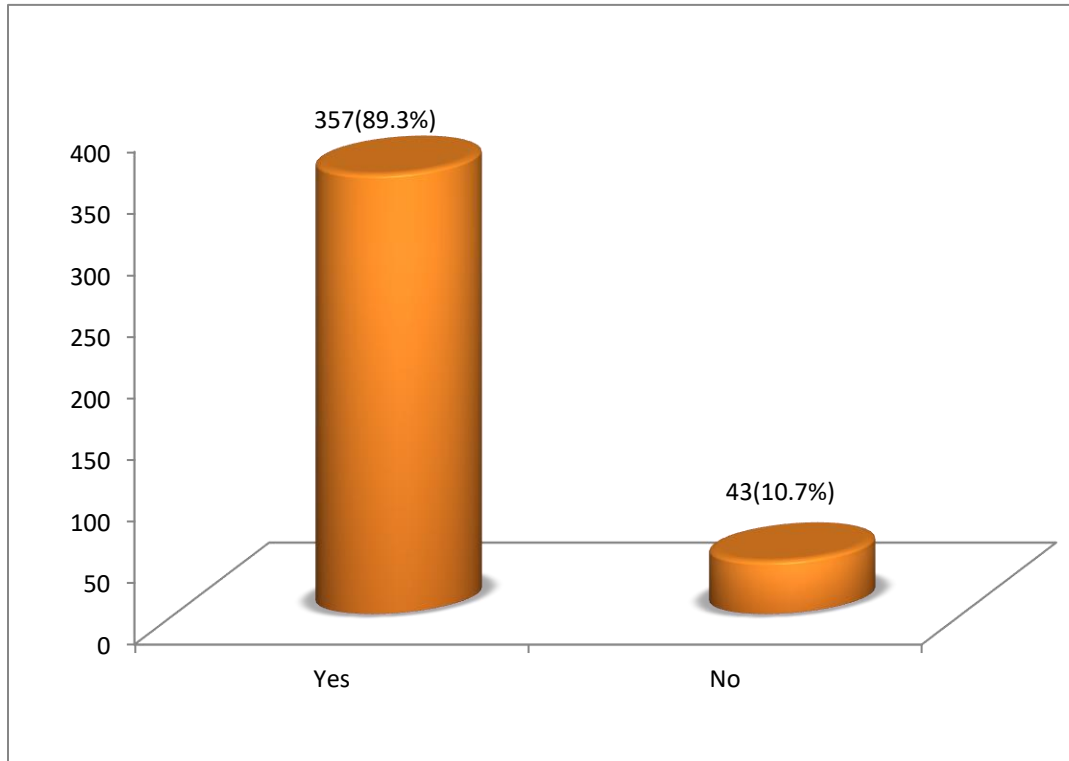


Figure 4: Believed Cultural practices that contribute to HIV

Impact of socio-cultural norms on HIV

Just over half of the respondents (51.0%) reported receiving HIV information and support through their religion, while 49.0% did not. Additionally, 68.5% of respondents were aware of local health interventions related to HIV, whereas 31.5% were not. This suggests that socio-cultural influences, particularly religious involvement, play a significant role in the dissemination of HIV-related information and the awareness of health interventions within the community.

Table 6: The impact of socio-cultural norms on HIV testing, treatment and care-seeking behaviour

Variables	Frequency	Percentage
Receiving HIV information and supporting Religion		
Yes	204	51.0
No	196	49.0
Aware of local health intervention		
Yes	274	68.5
No	126	31.5

Appropriate interventions and strategies for mitigating the prevalence of HIV

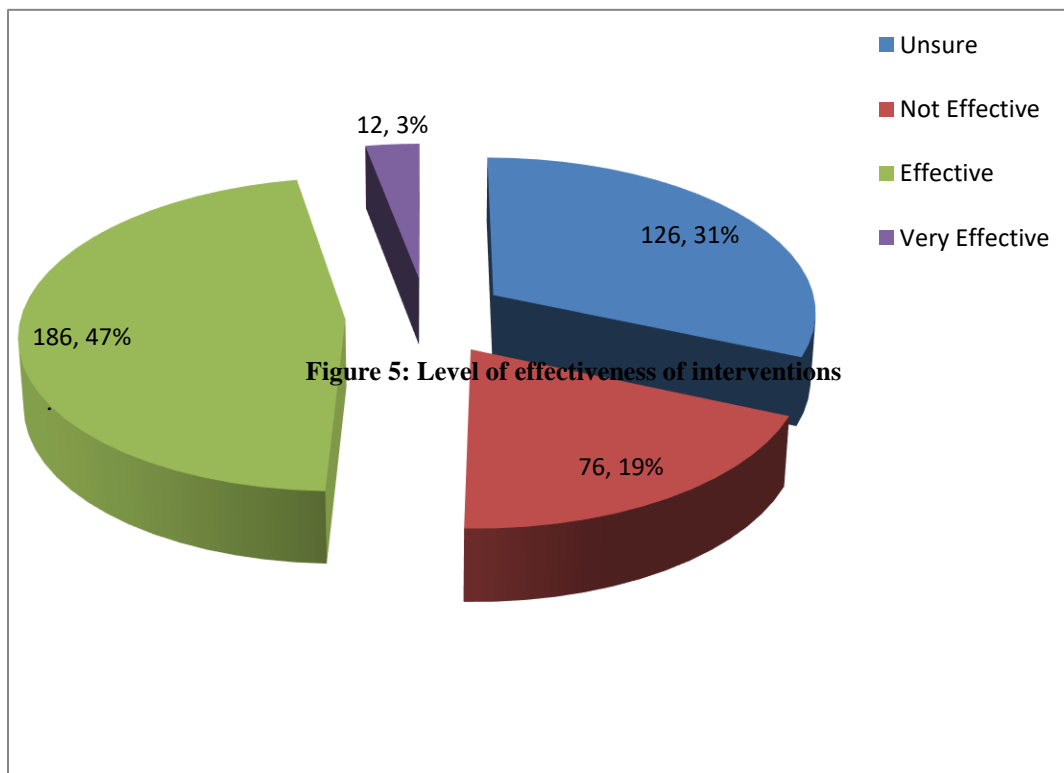
A majority were aware of HIV testing (69.0%) and condom distribution (68.8%) as key strategies. However, awareness was lower for antiretroviral therapy (41.8%) and educational programs (41.3%), with over half of the respondents being unaware of these important interventions (58.2% and 58.7%, respectively). This indicates a need for increased education and outreach to improve awareness and utilization of these critical HIV prevention and treatment measures.

Table 7: Appropriate interventions and strategies for mitigating the prevalence of HIV

Variables	Aware (%)	Not Aware (%)
HIV testing	276 (69.0)	124 (31.0)
Condom distribution	275 (68.8)	125 (31.2)
Antiretroviral therapy	167 (41.8)	233 (58.2)
Educational programmes	165 (41.3)	235 (58.7)

Effectiveness of Interventions

On the level of effectiveness of intervention, 31.0% and 47.0% of the respondents noted that the intervention is effective and very effective respectively while 19.0% noted that the intervention is not effective



Overall Knowledge about HIV

Overall, 60.2% of the respondents have good knowledge prevalence of HIV while 39.8% had poor knowledge of HIV.

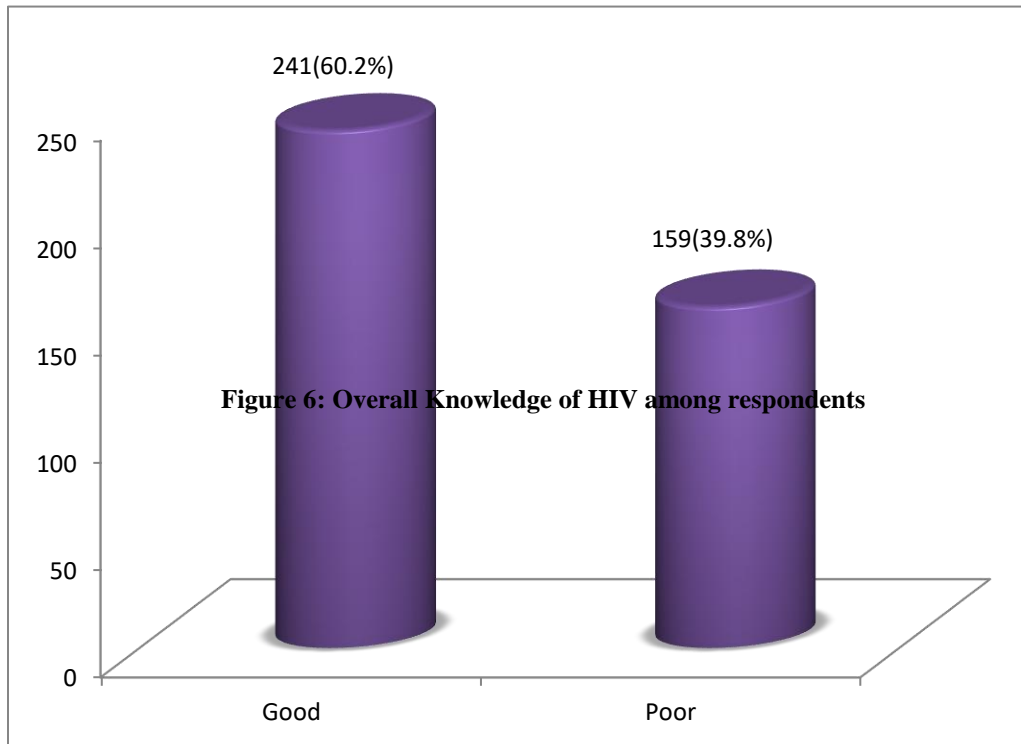


Figure 6: Overall Knowledge of HIV among respondents

Association between socio-demographic variables and knowledge of HIV prevalence

A significant relationship was found between age and HIV knowledge ($\chi^2 = 8.409$, $p = 0.015$), with younger respondents (≤ 30 years) having a higher percentage of good knowledge (67.0%) compared to those aged 31–40 years (53.8%) and over 40 years (51.4%). Gender also showed a significant association with HIV knowledge ($\chi^2 = 10.911$, $p = 0.001$). Males were more likely to have good knowledge (70.3%) compared to females (53.7%). Ethnic background had a strong influence on HIV knowledge ($\chi^2 = 159.262$, $p = 0.001$). All respondents from the Hausa and Igbo ethnic groups demonstrated good knowledge (100.0%), while none from the "Others" category had good knowledge (0.0%). Religion was another significant factor ($\chi^2 = 7.006$, $p = 0.008$), with Muslims showing a higher percentage of good knowledge (64.2%) compared to Christians (49.5%). Education level was strongly associated with HIV knowledge ($\chi^2 = 190.265$, $p = 0.001$). Respondents with tertiary education had the highest percentage of good knowledge (95.5%), whereas those with no formal education or "Others" had no respondents with good knowledge (0.0%). Occupation ($\chi^2 = 110.650$, $p = 0.001$) and income ($\chi^2 = 235.344$, $p = 0.001$) were also significantly associated with HIV knowledge. Civil servants (97.1%) and respondents earning above 50,000 Naira (99.1%) were more likely to have good knowledge, while housewives (0.0%) and those earning $\leq 10,000$ Naira (0.0%) had the poorest knowledge levels. These findings underscore the importance of socio-demographic factors in influencing knowledge about HIV.

Table 7: Association between socio-demographic variables and knowledge of HIV prevalence

Variables	Knowledge		χ^2	p-value
	Good (%)	Poor (%)		
Age groups			8.409	0.015
≤ 30	140 (67.0)	69 (33.0)		
31 – 40	63 (53.8)	54 (46.2)		

> 40	38 (51.4)	36 (48.6)		
Gender			10.911	0.001
Male	111 (70.3)	47 (29.7)		
Female	130 (53.7)	112 (46.3)		
Tribe			159.262 ^f	0.001
Yoruba	179 (63.9)	101 (36.1)		
Hausa	28 (100.0)	0 (0.0)		
Igbo	34 (100.0)	0 (0.0)		
Others	0 (0.0)	58 (100.0)		
Religion			7.006	0.008
Islam	188 (64.2)	105 (35.8)		
Christianity	53 (49.5)	54 (50.5)		
Level of education			190.265 ^f	0.001
None	0 (0.0)	26 (100.0)		
Primary	29 (78.4)	8 (21.6)		
Secondary	88 (48.6)	93 (51.4)		
Tertiary	124 (95.5)	6 (4.6)		
Others	0 (0.0)	26 (100.0)		
Occupation			110.650 ^f	0.001
Civil servant	68 (97.1)	2 (2.9)		
Personal Business	92 (63.9)	52 (36.1)		
Housewife	0 (0.0)	31 (100.0)		
Artisans	81 (52.3)	74 (47.7)		
Income			235.344 ^f	0.001
≤ 10,000	0 (0.0)	76 (100.0)		
10,001 – 50,000	130 (61.3)	82 (38.7)		
> 50,000	111 (99.1)	1 (0.9)		

^f-Fishers exact test

Association between socio-demographic variables and believes and cultural practices contributing to HIV

Age was significantly associated with beliefs and cultural practices contributing to HIV ($\chi^2 = 97.587f$, $p = 0.001$). Nearly all respondents aged 30 years or younger (99.5%) and those aged 31–40 years (93.2%) believed these practices contribute to HIV, compared to only 54.1% of respondents over 40 years. Gender also played a significant role ($\chi^2 = 24.484$, $p = 0.001$), with 98.7% of males and 83.1% of females agreeing that beliefs and cultural practices contribute to HIV. Education level was also significantly associated ($\chi^2 = 74.445f$, $p = 0.001$). All respondents with no formal education, primary education, and other categories (100.0%) believed in the contribution of cultural practices to HIV, whereas this belief was held by 98.3% of those with secondary education and 69.2% with tertiary education. Occupation ($\chi^2 = 98.376f$, $p = 0.001$) and income ($\chi^2 = 51.667f$, $p = 0.001$) also showed significant associations. Belief in the impact of cultural practices on HIV was highest among housewives (100.0%) and those earning ≤ 10,000 Naira (100.0%), with civil servants showing the lowest belief at 50.0%. These results highlight how socio-demographic factors influence perceptions of the role of cultural practices in HIV transmission.

Table 8: Association between socio-demographic variables and believes and cultural practices contributing to HIV

Variables	believes and cultural practices contributes to HIV		χ^2	p-value
	Yes (%)	No (%)		
Age groups			97.587 ^f	0.001
≤ 30	208 (99.5)	1 (0.5)		

31 – 40	109 (93.2)	8 (6.8)		
> 40	40 (54.1)	34 (45.9)		
Gender			24.484	0.001
Male	156 (98.7)	2 (1.3)		
Female	201 (83.1)	41 (16.9)		
Tribe			23.750 ^f	0.001
Yoruba	237 (84.6)	43 (15.4)		
Hausa	28 (100.0)	0 (0.0)		
Igbo	34 (100.0)	0 (0.0)		
Others	58 (100.0)	0 (0.0)		
Religion			128.820 ^f	0.001
Islam	293 (100.0)	0 (0.0)		
Christianity	64 (59.8)	43 (40.2)		
Level of education			74.445 ^f	0.001
None	26 (100.0)	0 (0.0)		
Primary	37 (100.0)	0 (0.0)		
Secondary	178 (98.3)	3 (1.7)		
Tertiary	90 (69.2)	40 (30.8)		
Others	26 (100.0)	0 (0.0)		
Occupation			98.376 ^f	0.001
Civil servant	35 (50.0)	35 (50.0)		
Personal Business	139 (96.5)	5 (3.5)		
Housewife	31 (100.0)	0 (0.0)		
Artisans	152 (98.1)	3 (1.9)		
Income			51.667 ^f	0.001
≤ 10,000	76 (100.0)	0 (0.0)		
10,001 – 50,000	169 (79.7)	43 (20.3)		
> 50,000	112 (100.0)	0 (0.0)		

Discussion

The age distribution of respondents shows that a majority (52.3%) were under 30, a demographic vulnerable to HIV due to risky sexual behaviors (Olumide et al., 2022). Females comprised 60.5% of participants, reflecting gender disparities in negotiating safer sex (Adejumo et al., 2023). The majority (70%) identified as Yoruba, highlighting the influence of varying cultural practices on HIV prevalence (Omole et al., 2021). While most respondents had secondary (45.3%) or tertiary (32.5%) education, suggesting better HIV knowledge (Nwabueze et al., 2022), some had limited or no formal education, indicating a need for targeted education. Over half (53%) earned between ₦10,001 and ₦50,000, indicating potential barriers to accessing HIV services due to financial constraints (Akinyemi et al., 2023).

The study revealed 100% awareness of HIV among respondents, a positive indicator aligning with other studies in Nigeria. However, depth of knowledge and accuracy remain crucial for effective prevention (Afolabi et al., 2023). The internet was the most common source of HIV information (41.5%), followed by health workers (28.5%), radio/TV (21.0%), and religious leaders (9.0%). While the internet's prominence highlights accessibility, it can lead to misconceptions (Nwankwo & Okoye, 2022). Misunderstandings, like confusing HIV's name, highlight the need for improved education (Obi et al., 2023). Awareness of unprotected sex, mother-to-child transmission, and needle sharing varies, indicating knowledge gaps (Adeleke et al., 2023). Despite high correct knowledge, notable misconceptions about HIV transmission exist among respondents: 17.2% incorrectly cited mosquito bites, 11.5% cited sharing food utensils, and 10.8% cited sharing toilets. Such beliefs stem from socio-cultural factors and insufficient education (Chukwu et al., 2021). These misconceptions can lead to stigma against individuals living

with HIV, reflecting the need for comprehensive HIV education. Encouragingly, 92.0% of respondents believe in HIV prevention through methods like condom use and regular testing (Nwafor et al., 2023). However, gaps remain as 8% don't believe in HIV prevention, influenced by traditional beliefs and mistrust in medical practices (Obi & Udeh, 2022). A majority (90.5%) of respondents recognize the importance of using sterile needles to prevent HIV, reflecting good awareness of transmission through contaminated blood (Adesina & Afolabi, 2023). Abstinence is seen as a preventive measure by 82%, aligning with religious and cultural teachings (Adeoye & Yusuf, 2021). However, 18% do not see abstinence as effective. Awareness of HIV through community programs is acknowledged by 61.8% of respondents.

Moreover, 81.5% believe that increased HIV knowledge can reduce its prevalence, while 60.2% have good knowledge about HIV. Education and socio-cultural factors like stigma significantly influence HIV understanding and prevention (Abimbola et al., 2022). This study also revealed that 89.3% of respondents believe cultural practices contribute to the prevalence of HIV. These practices include the use of unsterilized blades during rituals or traditional circumcision. According to Oyekale and Oyekale (2021), these practices are prevalent in some communities and contribute to high HIV infection rates. While 51.0% of respondents received HIV information that supports their religious beliefs, 49.0% did not. Additionally, 68.5% were aware of local health interventions related to HIV. These findings highlight the interplay between socio-cultural factors and public health efforts in combating HIV in Nigeria, emphasizing the need for culturally sensitive interventions.

Conclusion

This study revealed that while many residents are aware of HIV, there are varying levels of knowledge, with some misconceptions persisting about transmission and prevention. Cultural beliefs and practices were identified as significant factors that both positively and negatively influence the community's approach to HIV prevention and care. These cultural elements often dictate behaviors, which can either hinder or facilitate the adoption of safe practices and the utilization of HIV-related services. Socio-cultural norms were found to have a profound impact on the community's engagement with HIV testing, treatment, and care. These norms often create barriers that discourage individuals from seeking necessary healthcare services due to fear of stigma or social ostracism. Based on these insights, the study concluded that to effectively reduce the prevalence of HIV in Asa LGA, it is essential to implement interventions that are culturally sensitive and tailored to the community's unique social dynamics. These interventions should focus on education and awareness campaigns that address specific cultural beliefs and misconceptions while promoting positive norms that encourage testing, treatment, and care-seeking behaviors.

Recommendations

- i. Government should develop comprehensive HIV awareness campaigns using various media channels to correct misconceptions and strengthen healthcare facilities to improve access to HIV services.
- ii. The community is encouraged to organize workshops and seminars to educate residents about HIV, create safe spaces for discussions, and establish support groups for those living with HIV.
- iii. Residents are advised to seek reliable HIV information, engage in community education programs, support efforts to reduce HIV stigma and discrimination, and regularly participate in HIV testing and health check-ups.

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