Persistence of Risky Sexual Behaviours and HIV/AIDS: Evidence from Qualitative Data in Three Nigerian Communities

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Abstract

The behavioural factors that are driving HIV/AIDS remain largely elusive despite vast number of quantitative studies. It is widely acknowledged that sensitive issues like sexual mores are better studied, using the qualitative methods. An ethnographic semi-longitudinal study was conducted in three of Nigeria’s communities with high and/or low HIV/AIDS prevalence rates in order to ascertain the risky behavioural factors that are still driving the epidemic despite colossal investment in preventative programmes. The focus group discussion, in-depth interviews and key informant methods were utilized to gather data from members of the communities, opinion leaders, policy-makers, healthcare practitioners and religious leaders. The nine factors that appear to be driving the infection are: transactional sex, age of sexual debut and lack of parental care, misconceptions about HIV and AIDS, sexual partnership beyond spouses and primary partners, mismatched sexual desire, fatalism, syndrome of denial, condom use, and alcohol. The outcomes of the study have implications for the prevention of the HIV/AIDS epidemic in the country (Afr J Reprod Health 2012; 16[1]:113-123).

Résumé


Keywords: Behavioural; Risky sexual behaviour; Ethnographic; Qualitative and quantitative methods

Introduction

The HIV/AIDS epidemic remains one of the most challenging of all infectious diseases of poverty in the absence of cure. Sub-Saharan Africa with largest number of poor countries in the world is more affected by the disease than other countries in the other sub-regions. The 2009 statistics indicate a 5.0% adult prevalence rate among persons between 15 and 49 years in sub-Saharan Africa in contrast to 0.2% in Middle East and Northern Africa; 0.3% - South and South East Asia; 0.1%, - East Asia; 0.2%, - Europe and Central Europe and 0.5% in North America.
Secondly, about 67.6% of all adults and children living with HIV in the world in 2009 were in sub-Saharan Africa. Thirdly, the sub-region recorded 72.2% of all AIDS related deaths (viz., the largest number in the world for the same period)\(^1\). Finally, only about 37% of those eligible for treatment had access to life saving medicines in sub-Saharan Africa in 2009 as opposed to 42% in Central and South America, 48% in Oceania, 48% in the Caribbean, and 19% in Eastern Europe and Central Asia\(^2\).

Although considerable investment in prevention programmes has raised the level of awareness on the etiology of HIV/AIDS and how it can be prevented through a variety of strategies, nonetheless millions of Africans are still taking risky behaviours. The result is the perceptibly slow decline in the number of new HIV infections in Africa when compared to the other sub-regions in the world. A major factor contributing to the disease is unprotected sexual intercourse with multiple partners. An awareness of this fact has stimulated interest in the study of all manner of risky behaviours that are still driving the disease in Africa.

As example, recent studies in parts of Africa attribute risky sexual behaviours to gender with more young men than women likely to take risk. There are reports about the role of fatalism\(^3\) including the prevailing economic conditions\(^4\). Other authors draw attention to the interplay on the one hand between sexual abuse\(^5\), alcohol use\(^6,7\), poor self-esteem\(^8\), ethnicity\(^9\), marital status (i.e., with particular reference to the young and unmarried)\(^10\) and risky sexual behaviours on the other. Finally, reference has also been made to the influence of religious affiliation\(^11\) including personality and behavioural attributes (e.g., the vulnerable in the population) in risky sexual behaviours\(^12\).

This study was conceived against the backdrop of the foregoing discussion with overarching aim of investigating the factors that influence sexual risk taking behaviours in the spread of HIV in Nigeria which has notably failed to drastically reduce its HIV/AIDS prevalence rate. The study was also driven by the desire to produce outcomes that can engender effective prevention programmes in the country.

Overview of HIV/AIDS in Nigeria

Nigeria where the study was conducted is the most populous state in Africa and is among the first twelve in the world\(^13\). It has the second highest number of HIV-infected people in the world\(^14\). The HIV prevalence rate in the country rate which is currently 3.6 percent\(^15\) rose from 1.8 percent when the first cases of AIDS were reported in 1986 to 5.8 percent in 1999 due to government inaction. It is believed that 2.95 million Nigerians are living with the disease while 280,000 AIDS related deaths are recorded annually. Moreover, more than 2.2 million have been orphaned while 380,000 new infections are reported annually. Thirdly, 56,000 infants are believed to be HIV infected during pregnancy\(^16\).

The foregoing statistics lead observers to conclude that even though sub-Saharan Africa contributes the most to the HIV/AIDS burden worldwide, Nigeria, the most populous in the sub-Region contributes 9 per cent to the global burden of the disease. Consequently, HIV/AIDS remains a challenging epidemic in Nigeria\(^17,18,19,20,21,22\).

It is widely believed that a change in lifestyle through, for example, the practice of safe sex by all Nigerians could singularly and significantly check the spread of the disease in the country. Yet, this is not happening inspite of colossal investment of time, energy, and resources in control programmes over the past decade. Large numbers of Nigerians still indulge in risky sexual behaviours even though various reports from studies indicate that vast numbers of them are aware of dire socio-medical consequences of HIV/AIDS and also one of the effective preventive strategies, namely, condom use.

The critical issue in Nigeria today is to have a holistic understanding of the factors that are still driving risky sexual behaviours despite the heightened level of awareness on prevention strategies and the socio-medical consequences of the disease. The need for information on sexual risk taking behaviours cannot be underestimated in the development of intervention to check the spread of the disease in the population. However, any attempt to garner rich information on sensitive risky sexual behaviours requires innovative methodology. This study was designed to gather information on sensitive behavioural issues like...
those on sexual mores etc., using the qualitative rather than the quantitative methods.

Methods

Research Setting

Three Nigerian communities were selected from two states in Nigeria for the study. The first of the communities is Ugep, the headquarters of Yakurr Local Government Area which is about an hour’s drive from Calabar the capital of Cross River State. It is a stopover for long distance drivers while its inhabitants are largely farmers. Because of its location, it has attracted migrants from various ethnic groups, namely, Igbo, Ibibio, and Hausa. Ugep has a very high HIV prevalence rate that is put at 12.7%, which is well above the national of 3.6% to 4.6%.

The second research site are two communities, - Olunloyo and Badeku. The former is semi-urban while the latter, Badeku is a predominantly rural settlement. These Yoruba speaking settlements have also attracted migrants from other Yoruba and Nigerian towns. The residents of Olunloyo are primarily petty traders and civil servants while those of Badeku are mostly subsistence farmers and hunters. The prevalence rate for the communities is about 2.2%.

As can be seen, Ugep and Olunloyo were purposively selected to reflect urban and semi-urban attributes and sero-prevalence rate of HIV/AIDS. Consequently, the choice of Ugep (a high HIV prevalent site and predominantly semi-urban settlement), Olunloyo (a semi-urban area with low HIV prevalence rate), Olunloyo (predominantly semi-urban) and Badeku (a rural settlement) provided an opportunity to compare the socio-economic and contextual factors in the spread of HIV.

Entry into Communities

An ethnographic semi-longitudinal study was conducted to ascertain the factors that influence risk taking behaviours in the spread of HIV/AIDS in the targeted communities. The work began with entry into the various communities through their traditional rulers and chiefs because it was vital to secure their support and cooperation in the implementation of the study. They were accordingly briefed about the study and assured that the outcomes will be shared with them upon completion.

Having received training on various qualitative methods, the field workers were introduced to the traditional rulers and chiefs and subsequently deployed to gather data in the communities. Accommodation was provided for them in the communities while offices were hired to serve as the rallying point for the workers as well as the place to store equipment, materials etc. Field supervisors regularly visited the field workers throughout duration of the field work which lasted for about two years.

Focus group discussions (FGD), in-depth interview (ID) and key informant interview (KII) methods were used to gather important social and cultural risk factors for HIV/AIDS.

Focus Group Discussion

Participants were recruited through local community organizations, such as religious institutions, markets, and neighbourhood groups. The field workers visited community leaders and urged them to identify those willing to share their knowledge about HIV and AIDS issues. They enlisted the help of the leaders to invite eligible individuals to participate in the research. The leaders described the purpose of the study during the announcements and urged volunteers to see research assistants, who were usually at the designated places in the community. In all twenty focus group discussion sessions were held.

In-depth Interviews

About thirty In-depth interviews were conducted to obtain detailed information from selected respondents about sexual practices and HIV and AIDS prevention. Approximately 25 to 30 in-depth interviews were conducted in the three semi-longitudinal sites.

Key Informant Interviews

Key informants interviews were also conducted with local policy makers, opinion leaders, health care practitioners, and religious leaders from the study communities. Participants were asked to suggest others with special knowledge of the same
issues. Such consultations made it possible to assemble a knowledge-rich pool of people to be interviewed. Thirty of them spread across the groups/communities were interviewed.

Data Collection Strategy

The skill, commitment, and motivation of field personnel were critical to the successful implementation of the study. First, field interviewers and supervisors position were widely advertised in the study communities. After applications were reviewed, those who were short-listed using the selection criteria were interviewed. The outcomes of the interview exercise guided the final selection of field personnel. The requirements for selection were postsecondary education, fluency in English and in the language of the study communities, and a demonstrated interest in the study.

A manual was developed to guide interviews and other field activities. The manual outlined the rules and regulations for research staff; instruction for mapping study communities using the enumeration maps by the Nigerian Population Commission for the 2006 census; instructions on techniques for conducting interviews, and clear guidance on how to ask questions and handle unanticipated problems.

Both Nigerian and international consultants conducted training sessions for field personnel. The field manual was used during training sessions.

One trained field researcher conducted each FGD and another took notes. Permission to record the discussion was gained from participants at the beginning of each FGD. Some FGDs were conducted in English but most were in local language. All the FGDs were audio-recorded. Before an FGD session began, facilitators read the informed consent form to participants, and those who agreed to participate were required to sign or thumbprint the consent form. A brief rapport-building phase of open discussion then took place; when facilitators observed that participants were talking among themselves, they directed the conversation to FGD topics. Each FGD session lasted between one and two hours. Participants were offered refreshments after the session.

Interviewers held IDI and KII with participants in a place convenient for the respondents. Each interview session lasted about 60 minutes. At the beginning, interviewers read an informed consent form to the respondents and their consent was obtained. All IDI and KIIs were audio-recorded, and interviewers also took notes.

Transcription of Data

Interviews were recorded using audio-recorders. The observers noted nonverbal communication during discussions. Each recording was appropriately labeled with the category of respondent (e.g., male youth, female adult, etc), date of interview, type of interview (FGD, IDI, or KII) and location (e.g., Ugep, Olunloyo, or Badeku). The recorded interviews were sorted by FGD or KII and then arranged by site and category of respondent.

Quality assurance was an integral part of the study, conducted prior to data collection and also throughout the duration of the study. Field supervisors were trained to supervise and monitor data collection, storage, data entry, and analysis. The data were recorded into tapes, transcribed and reproduced for analysis.

Each recorded interview was transcribed within a few days. Transcribers were trained to transcribe everything verbatim. Copies of written transcripts were sent to the office for data analysis. The transcripts were analyzed site by site and across sites and then manually by theme. Content analysis of the materials was undertaken by trained field workers.

Ethical Consideration

The principal researchers participated in an online ethical training course and received certification. They in turn trained the field assistants on ethical issues. Field assistants were given clear instructions to ensure that respondents signed the consent form while the non-literate participants were required to thumb print.

The study received approval from the ethics review boards of the partner institutions, namely the University of Ibadan and Northwestern University and also from Nigeria’s national ethics
review board. The protocol was submitted first to the University of Ibadan Board and then to the National Board. The approved version from the local boards (i.e., Nigeria’s) was later passed through the Northwestern Board. All amendments and/or modification to the protocol during implementation were submitted to the Boards for approval before they were applied.

Consent of all those who participated in the FGDs, IDIs, and KII interviews was sought in writing or by thumb-printing prior data collection in compliance with the ethical requirements of the various boards.

Finally, the outcomes of the study were shared with members of the community at the various sites. Drama sketches were used to drive the main issues in the study home to the participants.

Results

The factors affecting high risk and related behaviours are listed and subsequently discussed below, using excerpts from focus groups discussions, in-depth, and key informant interviews. They enrich our understanding of the factors affecting risky sexual behaviour among Nigerians. The key factors were examined under the broad themes transactional sex, age of sexual debut and lack of parental oversight, misconceptions about HIV and AIDS, sexual partnership beyond spouses and primary partners, mismatched sexual desire, fatalism, “Syndrome” of denial, condom use, and alcohol use.

Transactional Sex

Transactional sex was acknowledged to be widespread despite a reasonable level of awareness about HIV/AIDS and its socio-medical consequences. According to participants, financial greed or the prospect of being offered a job or promotion and/or tangible gifts are motivations for transactional sex. Here are a few excerpts from interview sessions:

Some children love money. They are never satisfied with whatever money their parents are giving them. They will be telling their parents that they want to buy what someone else bought and the parents keep telling them to be patient and they refuse. This also encourages this (transactional sex) act.

Another contributor corroborated this practice:

Another difference is the some girls love money and despite the fact that their parents are taking care of them at home; they never listen to their mother and go on their ways. If they see men giving them money (they will follow them), and men these days believe that girls that collect money or gift from them, they must have sex with such a person.

Finally, the possible explanation for these behaviours is summarized in the following excerpts:

Just as you said when you are in need of employment, there is nothing you can do (other) than to give yourself (sexually). At times you want to buy favour in the office with your boss; if he is a male there is nothing (else) you can do so that when promotion comes you will be promoted.

Transactional sex was mentioned repeatedly in focus group discussions and in-depth interviews at the various sites. In difficult economic circumstances, where families lack the wherewithal to support all members or cannot afford to live in decent accommodations, people look for other ways to obtain shelter. One participant observed that:

For instance, some (children) when they offend their parents, their parents drive them out and say do, don’t come back to my house. By doing that they (especially the girls) don’t know what to do or where to go. They go and meet anybody and because they don’t know where to sleep, they can sleep anywhere.

Or at times:

It comes from parents. If they don’t take care of their (daughters) or (are) too harsh on them, the child can be going after men and having sex with men hence she derives pleasure in doing it and she can continue if parents do not give to their children. Such a child can because of this start having sex with men.

The pervasiveness of transactional sex in Nigeria is not only due to poverty but weakening or obliteration of time-honoured values of candour, integrity, and transparency. Values that
were embraced in the past have been supplanted by decadent ones. Nigeria is known to be among the most corrupt countries in the world\textsuperscript{24}. This malaise has undermined mores, institutions, interpersonal and gender relations.

Another example of transactional sex is the sugar daddy and sugar mummy phenomenon. This is a practice where young boys have sexual relationship with older women, or young girls with older men, not necessarily because of flow, but for financial gain to improve their life-styles, meet their basic needs, and overcome harsh economic conditions. The older and richer partner doles out money and gifts to the younger lover in exchange for company and sex. These lovers may at the same time be involved in other sexual relationships with their peers. One participant drew attention to this as follows:

\textit{Some boss don’t have something doing; they want to have a (relationship) with a rich lady that will give them money for them to (dress fashionably) like their friends. You see some of them saying “I have a sugar mommy and she is giving me money, she will be there for me in every respect.”}

Another participant noted:

\textit{There is the other woman I know, her husband is a tailor, but this woman is not satisfied with what her husband was giving her. So she was going out with other men until her husband died. She came to Ugep and still continued going out. She now started going out with a (young Igbo) boy. The woman became pregnant by the boy and she birth. She already has six children.}

Age of Sexual Debut and Lack of Parental Oversight

There was evidence of sexual debut occurring earlier than generally believed among both boys and girls. For girls, it was as early as 10 – 12 years and for boys, 15 years. Some respondents seemed to think that eagerness for sex among girl- and boy-children was being influenced by pornographic films, which are freely available in stores, market places, internet cafes, and homes. One of the participants noted:

\textit{...that is what civilization brought. Among themselves or peers they will be asking one another that “have you had sex with girls before?” They count it as what you can be doing (recklessly) and be proud of. They do not (see) it as a big issue. Most of the boys do watch (porno) films and having watched these films they will be practicing (what they see).}

With respect to age of sexual debut, one observed:

\textit{Some do not reach 18 years now before they start having sex. Some start having sex at the age of 13 years. I have seen it in this community. As the world is now, it is not compulsory that the child should be matured unless (for) those ones who have the fear of God in their heart. There are some who reach 20 years before they start having sex because of the way they are (raised).}

Another said:

\textit{Some are doing it (sex) and others are not doing it (but) a little boy of 8 or 9 knows everything about sex more than an 18 year old girl.}

Also, cramped living conditions in many homes often expose children to sex at an early age.

Parents must be able to (sexually) take care of themselves at home. There are some children who are fifteen years old living with their parents in their single room; husband and wife, many want to have sex and these children may be seeing them, there trying to do the same.

One of the unintended consequences of the pressure to support families in difficult circumstances is the failure by parents to exercise supervisory control of their children. Parents leave home for work very early in the morning while children are left unattended at a formative stage of their lives. Such children run the risk of being exposed to sexual activities by others as indicated below:

\textit{To some extent that there are some parents who handle their children with strong hands but having left house to (go to) their places of work, they don’t know what these boys are doing after school hours. Some of (the boys) used to follow their friends to their girl
friends’ houses and from there they too start doing his thing.

Misconceptions about HIV/AIDS

Years of HIV/AIDS control programmes have not really eliminated misconceptions about the virus or disease. Many people still harbour erroneous ideas about HIV than turn encourages them to indulge in risky behaviour patterns, as argued by this respondent from Ugep:

How do we in our language call the disease?...a prominent chief referred to it as Akalang-pen (literarily white man’s disease that destroys us)...

Misconceptions about HIV/AIDS are not only found in the definition of the disease. There are deep rooted misconceptions about its transmission, especially among the illiterate in the population. However, similar views are shared by some better educated members of the community and argued by this respondent from Badeku:

...the people in the community who never (attended) schools used to say that people can suddenly have it (HIV), that they do not contact it. They still hold the opinion that we should not be using the same plates at home to eat with them...

Misconceptions about the disease also encourage Nigerians to believe in the preventative efficacy of traditional herbs. As an example, some resort to ingesting traditional herbs before and after sexual intercourse:

There is another way they are using to protect against HIV/AIDS. This can be done by using herbs. Most men who do not go to school have sex with women (then) take these local herbs immediately they finish sex, (believing that) all the things they might have (contracted) from the woman, they urinate it having taken medicine. The only way we know is that some people know that there is (this) kind of local herb they can take after having sex to protect them from contracting HIV/AIDS.

Another respondent in Ibadan noted:

There are beliefs at the local community level that there are local herbs and traditional medicine that as soon as they are rubbed on the private parts, they (protect) them from contracting HIV.

An FGD participant also shared the following:

I had a discussion with one of the top men in our local government on HIV. He was telling me that he’s a Muslim. He said there are some medicines they use on their private part and don’t need to use a condom. They can have sex with anybody flesh to flesh but not contract HIV. That is his own belief and I keep enlightening him, telling him that he should use condoms that he might contract it; that those herbs do not work.

Misconceptions also lead people into believing that the disease cannot be transmitted through anal sex:

Because most of them feel that (if) they do those things they are (not at risk of contracting) HIV and AIDS because (for) a man to man the blood is not really coming in contact with the other (man’s) blood, but it is not true...homosexuals say they do it through the anus so there is no blood coming out from there, so they will not (contract) HIV and AIDS or STD through homosexual (behaviour).

Such misconceptions deter many from seeing the disease as a serious public health problem and from considering voluntary counselling and testing. They often reason that they do not need to be tested for a disease that does not exist. Or, “why can’t we use our traditional herbs, as our forefathers did, to prevent and sexually transmitted disease and get on with our lives.”

Sexual Partnership beyond Spouses and Primary Partners

The phenomenon of sexual partnership was expressed in different ways. The practice of polygamy is still accepted in many Nigerian communities especially among Muslims and rural and inner city dwellers. Multiple sexual partnerships are also motivated by curiosity, namely, the desire to explore, or put it in the local parlance of men, “sample many women” partners.

One day I was sitting behind my neighbour’s shop. I was listening to some discussing about how they (sexually use) women. Some of them...
will say *onen jang konana oji* (meaning no body eats only one soup). So that is the thing that encourages them to what they are doing. Think some of them will say (it may be) a curse or something from the family. Some men will say other girl’s thing is like water while one is thick. So they are tasting to see whether the other one has water or not (cuts in) in the process of tasting, they forget AIDS is real. They will say that they are always protecting themselves. The funny thing is that after all (this) they will go and look for a decent girl to marry.

There is also male homosexuality (men having sex with men or MSM), with the perception that Western films play a role in encouraging homosexuality among young people in Nigeria. The way I heard men having sex with men was very fearful to me that I saw it as something that is difficult and not possible. They said that the reason why it happened was that they used to watch it in the films and from there, they too started practicing it whether it has meaning or not.

**Mismatched Sexual Desire**

Mismatch sexual desire among both married and unmarried people was identified as a factor. Sometimes the partners are unable for whatever reasons to meet each other’s sexual needs and demands. As observed by one of the participants: *Some woman if they say they are not in the mood, then the men say, well if you are not in the mood, let me go and look for somebody (outside the relationship) that is in the mood.*

Indeed one of the informants affirmed:

*Some men leave their wives when the refuse sex. Even some woman, you will hear a woman saying that her husband doesn’t (sexually) satisfy (her)*

Finally, there is the graphic remark:

*Especially married men! They are the people who spoiling the situation. Married men (emphasis) they dump their wives at home and they will be moving around town there where I am living. You will see them driving up and down the road, some girls will just come (out to) the filling station and stand there before you know it, cars will be picking them like that and (the drivers) are married men.*

**Syndrome of the Denial of AIDS**

One of the factors driving the spread of HIV/AIDS is the tendency for young people and others to regard the disease as a figment of the imagination. This denial “syndrome” encourages young people to indulge in unprotected sex and/or not see the risk in having multiple sexual partners. The denial “syndrome” is expressed in various ways such as the following from Ugep, a high HIV prevalence site:

*Some people do not agree that the disease exists in the world because the disease is not visible to the naked eye. It is not something that can be seen as such but is something that works in the blood. This is why some people are in denial.*

**Fatalism**

Despite efforts to educate the public about HIV/AIDS and make information freely available, some people are inclined to dismiss the disease claiming it is pure fabrication or a scare tactic to stop people from having a good time. This attitude reflects a deep fatalism which in turn encourages people to take risks or to fail to take action to prevent the disease. These individuals convince themselves that they disease does not really exist and they are vocal about not embracing messages of condom use, abstinence etc. one participant noted:

*I’d like to add that many people are still in denial. Many of them simply do not agree (that the disease exists). Some of them say *aji aji nabebe* (meaning: whether you eat or not, you will still die)*

According to another:

*Many of them will not believe that IDS exists in this community. Some of the young boys used to say in Lokurr dialect that *Lope ipo daja* (meaning: something must kill a man). The aphorism above expresses a deep fatalism in the community which deprives its members of the control necessary to take action against a*
perceived threat to life and death. According to another:

....Anyway and anyhow you die, It’s the way that God has destined you to die...

The feeling of “what will be, will be” pervaded the discussion and reactions when they were asked to provide explanations for non-use of VCT centres. The story about the consequences of HIV has always aroused some sort of despondency to the point that they seemed to become fatalistic about their ability to avoid becoming infected. According to a Youth in Benue:

There is denial for some people in Otukpo. Here there is a belief that if your child is infected with the virus, he or she is a wayward child; but youths believe that death is death, no matter the cause.

Condom Use

Many respondents were aware of the diseases and had knowledge of how to prevent it. One participant from a Badeku focus group discussion said:

....On the issue of using condom, as far as I’m concerned, I have used it before; there is nothing there in terms of enjoyment for the husband. We accept that this thing can prevent infection from man to woman. It is the man that is supposed (to decide) whether to use it or not.

There is a risk in having the final decision to use- or not use – a condom lie solely with the man especially if he engages in multiple partnerships, a polygamous relationship, and/or transactional sex.

Alcohol Use

Alcohol, a catalyst for risky sexual behaviour, is widely consumed in Nigeria. Some participants argued that alcohol use is small quantity for beginners, or large quantity for habitual drinkers, could cloud the judgement needed to minimize HIV risk associated with sex. According to a respondent:

The use of alcohol usually causes (first intercourse) many times.

Also, some traditional medicines that are freely sold in market places and/or villages and towns by mobile vendors in Nigeria have substantial alcohol. The vendors who are skilled marketers often use loudspeakers to attract customers. One cannot underestimate the role of alcohol or alcohol based medicinal concoction in the spread of HIV/AIDS.

Conclusion

As amply found in this study, poverty plays a very important role in risk taking sexual behaviours in Nigeria. Currently about two-thirds of Nigerians live on two US dollars a day. This implies millions on Nigerians hardly have resources to live a good life let alone look after their families effectively. It is therefore not surprising that transactional sex loomed large among the factors affecting risk taking. Vast numbers of people in search of elusive jobs or promotion to higher positions or admission into higher institutions are willing to trade their bodies in return for these favours. Object such as clothes, food, and money are the material nexuses for transactional sex in the three communities, with differences being in emphasis rather than on substance.

Secondly, sexual debut is at very young age, about 8-12 years and is also socially approved in Nigeria. Parents who are unable to feed their girls-children are ever willing to look the other way if someone is prepared to assume responsibility in return for sexual favours. They also often accede quickly to their betrothal to older persons who may be married to other women.

Thirdly, misconceptions about the diseases are still widespread with many still believing that the disease does not exist or attempting to rationalise its existence through fatalistic attitudes. Consequently, they are not inclined to use condom during sexual intercourse with casual partners. Also, alcohol in small or large quantity emboldens Nigerians. Some of the alcohols are locally brewed with very high alcohol content. They intoxicate very quickly and push those who consume into sexual activity.

Fourthly, lack of parental oversight cannot but be a driving force in a country where the family structure is rapidly breaking down due to huge pressures on parents to survive economically. These parents leave home very early in the day for...
their farms or shops and often with little resources for the children left at home or sent to school to buy snacks. This leaves the children open to temptation from the predators in their communities. Besides, traditional moral codes are also giving way to life-styles that are perceived to be progressive or enlightened, even more licentious. Pornographic films are widely available in many of the communities and children with little or no parental oversight spend their time on their way back home watching these movies in kiosks and shops around the communities. All these impact on the life of the children and even adults.

In concluding, it is recommended that health messages be customized to address not only to emphasize condom use as a preventive strategy against HIV/AIDS but to address the different aspirations. It is by adopting interventions that take into account the factors affecting risk taking that behavioural change which will lead to drastic reduction of HIV/AIDS infection can be achieved within the shortest possible time.

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