Perceived Sexual Attitudes and HIV/AIDS-Health Seeking Behaviours of People Living in the Fishing Community of Akwa Ibom State, Nigeria

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Authors’ contributions

This work was carried out by two authors. Author FA conceived and designed the study, wrote the protocol, carried out data collection and wrote the manuscript. Author AU helped in the literature search, data collection and analysis of the results. Both authors read and approved the final manuscript.

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ABSTRACT

Background: Despite the tremendous efforts made to reduce the burden of HIV/AIDS in many countries, there are still gaps in the control of spread of HIV-infection in Nigeria, especially in the coastal areas due to inappropriate life style and preference for traditional care of people living with the disease.

Aim: The purpose of this study was to assess the sexual attitudes and HIV/AIDS-healthcare seeking behaviours of people living in the fishing community of Okposo, Akwa Ibom State, Nigeria.

Methods: This was a cross-sectional descriptive study of 600 people living in the fishing community, who were assessed for perceived sexual attitudes and HIV/AIDS-health care seeking behaviours, using Attitude and Sexual Behaviour Questionnaire.

Results: Of the 600 participants, 339 (56.5%) were males and 261 (43.5%) females. Inspite of the
increasing awareness of the existence of HIV/AIDS, sexual attitudes were variable and inimical to
the fight against the disease; sexual urge was high; 27.7% males and 15.3% females had at least
two or more sexual partners; 13.8% males and 10.8% females hardly used condom during sexual
intercourse, while 15.5% males and 18.8% females would not undergo HIV testing. Perception on
the cause and mode of transmission of HIV/AIDS were poor. Perceived efficacy, confidentiality,
affordability and accessibility were reasons for choice of traditional care; about 61.0% of the
participants would not attend to infected individuals because of fear of being infected with the virus.

**Conclusion:** This study has shown that a lot still need to be done in Nigeria, especially in areas
with difficult terrain to reverse the trend of HIV/AIDS. Massive enlightenment campaigns are
necessary to serve as continuous efforts to increase and maintain high levels of motivation for
lifestyle modification.

Keywords: Coastal areas; sexual attitude; lifestyle; care; HIV/AIDS.

1. **INTRODUCTION**

HIV/AIDS still remains the most serious public health problems in many countries [1]. In sub-
Saharan region, the social and economic consequences are pervasive, because it affects
primarily the poor thereby exacerbating inequities in health and development [2,3]. There is
increasing evidence that HIV/AIDS is a major contributory factor to poverty in developing
countries [4,5]. A large number of adults are kept out from work and children are deprived of
parental affection. In recent times, it appears the prevention and control of HIV/AIDS in developing
countries is diminishing [6,7]. The advocacy has gone into hibernation and the interest in the
efforts to tackle the disease is waning [8-10]. In some developing countries, measures which
used to be stark reminders of its devastating effects and the need to do the right thing have all
but disappeared. Therefore, there is need for a new verve in the effort to tackle and control this
disease.

The impact of HIV/AIDS has compounded health and development crisis in many countries1.
Evidence in some developing countries suggests that an already weakened health care delivery
system is further burdened by HIV/AIDS [4]. This is because this disease is known to generate
more poverty by sapping people’s health, strength and productivity [5]. It affects mostly the
same desperately poor countries reeling from other chronic infectious diseases [11]. However,
unlike other chronic diseases with possible cure, preventive intervention is the only hope of taming
the HIV/AIDS in almost every country [12]. This seems to suggest that there is need for a
common concern in severely affected countries to organize and position their healthcare
services, for purposes of tackling this deadly and debilitating disease through public awareness.

In recent years, Nigeria has experienced a dramatic resurgence of HIV/AIDS and almost an
entire population of more than 150 million people is at risk [13]. Reports suggest that about 3-4
million Nigerians are living with HIV/AIDS, and only a tiny fraction has access to life-saving
antiretroviral drugs [6,7,14]. It is estimated that the vast majority of people living with the disease
are now taking to complementary and alternative care. Increasingly; it appears there is a greater
risk of being infected because of poor management of HIV/AIDS in the country. Regrettably, despite the tremendous efforts
made by various governments and the donor agencies, with respect to provision of huge sums
of money for prevention and treatment, there seems to be no commensurate results. This may
have been due largely to official corruption and the absence of collaborations in the country. Hence, there is need for a comprehensive
management plan that will encourage willing corporate organizations to key into a common
goal of fight against the disease.

Akwa Ibom State is one of the major oil producing States in Niger Delta region of Nigeria. The State has a demographic profile dominated
by unemployed youths. The impact of global economic downturn has led to the creation of
alternative means of livelihood [15,16]. With the increasing levels of poverty, many youths and young adults are involved in various non-white
collar jobs including fishing for survival [14]. Increasingly, concerns have been raised about
the high incidence of HIV/AIDS among the people in the fishing and coastal areas of the
State. Unfortunately, despite the increasing evidence attributing the upsurge of HIV/AIDS to
their sexual behaviours and attitude, awareness of prevention and control of HIV/AIDS is lacking
[17]. Few reports available lack the required data to adequately address the nature of care given to
the people living with HIV/AIDS in these fishing communities [14]. This study therefore aimed at assessing the perceived sexual attitude and care of the people living with HIV/AIDS in Okposo, a fishing community in Ibeno Local Government Area of Akwa Ibom State. It is hoped that the findings of this study will increase awareness and provide the needed energy and commitment to reduce the incidence of HIV/AIDS, not only in Akwa Ibom State, but Nigeria as a whole.

2. MATERIALS AND METHODS

2.1 Location of the Study

The study was carried out at Okposo, one of the several ancient fishing communities located at the remote riverine part of Ibeno Local Government Area of Akwa Ibom State, Nigeria. It is about 19 Kilometres from Upenekang, the Local government headquarter. Okposo fishing community is the biggest and is made up of Okposo I and II with a population of over 11,000 people. The settlers live in various subgroups (settlements) both in Okposo I and II. Each subgroup has its local name for easy identification and administration. Although Ibeno is an oil producing area in Akwa Ibom State, the main occupation of the people of Okposo community is fishing. A sizeable number of the settlers also engage in trading. Although the fishing community has a health post, however, the only major health facility serving the area is the General Hospital located at the local government headquarter, 19 Kilometres away from the fishing port. There is no motorable road linking the fishing community and the local government headquarter. The mode of transportation is mostly by canoe.

2.2 Data Collection

This was a cross-sectional descriptive study of 600 inhabitants of Okposo fishing community. Using a two-stage random sampling method, a total of 600 participants were recruited into the study. The first stage of the sampling by balloting selected the location of the study, Okposo 1 and 11. Using the same balloting method, six subgroups of settlements within the study area were selected, 3 settlements from each. The participants were consecutively recruited into the study after informed consents were obtained. Five assistants from the area who were first of all educated on the basic information about HIV/AIDS in the questionnaire and trained assisted the participants to complete the questionnaire throughout the period of the study. They embarked on home to home visit to make sure the questionnaires were completed and collected. Those with little or no education were helped by the researchers to fill the questionnaires. The questionnaire consisted of two parts: the first part elicited information on sociodemographic variables such as gender, age, marital status, education attainment, occupation, and religion. The second part was the Attitude and Sexual Behaviour Questionnaire adapted from previous studies [18-22]. The researchers made little modification on the questionnaire to include questions for assessing attitude of the participants to care of people living with HIV/AIDS, as well as their sexual behaviours. The sample size was determined using the formula \( N = \frac{Z^2pq}{d^2} \) with 5% HIV/AIDS prevalence in Nigeria and a 3% sample error. To recruit more participants into the study, the calculation was done for Okposo 1 & II separately. The sum total of the calculated sample size required for the study was 600. Recruitment of participants was done with the help of the community leaders, who organized and encouraged people to take part in the study. The Attitude and Sexual Behaviour Questionnaire contains questions bothering on beliefs on existence of HIV/AIDS, possible causes and mode of transmission, sexual relationships; perceived sexual urge, number of sexual partners, sexual preferences, use of condom during sex, reaction to sex after knowledge of partner status, willingness to undergo testing. Participants were also assessed for healthcare seeking behaviours such as types; nature and place of seeking care for HIV infected partners or relatives and reasons for particular choice of care. Responses were yes or no, agreed, disagreed or no response, always high, sometimes high or no more; no change, sexual abstinence, use of condom or break up of relationship. This study was anonymous and approval was obtained from the Ethics and Research Committee of the University of Uyo Teaching Hospital.

2.3 Data Analysis

The results of the study were analyzed using the Statistical Package for social sciences (SPSS 17.0). The proportion of attitude, sexual and health care seeking behaviours of the settlers was determined. Sample means and percentages were calculated with which simple frequency tables were created. Standard
deviation from the mean was also calculated. Comparisons of categorical data were done by Chi-square test, using Yates-corrected factor and Fisher Exact test. The corresponding p-values were found to determine the level of statistical significance. The p-value of <0.05 was used to determine the level of statistical significance.

3. RESULTS

Of the 600 participants that were recruited into the study, 339 (56.5%) were males and 261 (43.5%) females. Table 1 shows the sociodemographic characteristics of the respondents. The age range of the participants was between 18 to 53 years old. The mean age for males was 38.1 ± 5.6 years and 29.2 ± 4.7 years for females; 51 (8.5%) males and 38 (6.3%) females were single. A total of 153 (25.5%) participants, consisting of 109 (18.2%) males and 44 (7.3%) females had no formal education; more males 133 (22.2%) had primary education; while more females 106 (17.7%) had secondary education. Majority of the participants 410 (63.8%) were married, 89 (14.8%) were single while 101 (16.9%) were either separated, divorced or widowed.

Table 2 demonstrates various attitudes and sexual behaviours of the respondents. A total of 279 (46.5%) males and 214 (35.7%) females were aware of the existence of HIV/AIDS; 60 (10.0%) and 47 (7.8%) lacked awareness ($X^2=0.010; p=0.992$); 73 (12.2%) males and 58 (9.7%) females were of the opinion that HIV/AIDS is caused by witchcrafts; 51 (8.5%) and 42 (7.0%) by evil spirits; while 215 (35.8%) males and 161 (26.8%) females claimed HIV virus can be due to biological cause ($X^2=0.207; p=0.902$). A total of 47 (7.8%) males and 44 (7.3%) females believed HIV virus can be contracted through sexual intercourse; 33 (5.5%) and 31 (5.2%) through contamination with blood products; 29 (4.8%) and 17 (2.8%) through kissing; 89 (14.8%) and 70 (11.7%) through mosquito bites, 67 (11.2%) and 47 (7.8%) by shaking hands with infected person; while 74 (12.3%) and 52 (8.7%) believed people can contract HIV virus by sharing personal items such as spoons, towels or clothes ($X^2=2.820; p=0.728$). There was statistically difference in sexual orientation as 332 (55.3%) participants practiced Man to woman; 7 (1.2%) man to man and 32 woman to woman ($X^2=25.223; p=0.001$). A total of 77 (12.8%) males 81 (13.5%) females had sex once a week; 123 (20.5%) males and 69 (11.5%) 2-4 times a week; 75 (12.5%) and 53 (8.8%) females two weekly; 53 (8.8%) males and 37 (6.2%) monthly; whil 31 (5.2%) and 21 (3.5%) occasionally ($X^2=8.561; p=0.073$). One hundred and sixty six (27.7%) males against 92 (15.3%) females had at least two and more sexual partners ($X^2=11.93; p=0.003$). This was statistically significant.

Table 1. Sociodemographic characteristics of the respondents

| Variables                      | Subjects             | Males n (%) | Females n (%) | Total n (%) |
|--------------------------------|----------------------|-------------|---------------|-------------|
| Mean age                       |                      | 38.1±5.6    | 29.2±4.7      |             |
| Educational level              |                      |             |               |             |
| No formal education            | 109 (18.2)           | 44 (7.3)    | 153 (25.5)    |             |
| Primary school                 | 133 (22.2)           | 77 (12.8)   | 210 (35.0)    |             |
| Secondary school               | 76 (12.7)            | 106 (17.7)  | 182 (30.3)    |             |
| Post-sec school                | 21 (3.5)             | 34 (5.7)    | 55 (9.2)      |             |
| Occupation                     |                      |             |               |             |
| Unemployed                     | 31 (5.2)             | 87 (14.5)   | 118 (19.7)    |             |
| Fishing                        | 173 (28.8)           | -           | 173 (28.3)    |             |
| Trading                        | 87 (14.5)            | 118 (19.7)  | 205 (34.2)    |             |
| Others (shoe mending, tailoring, etc.) | 48 (8.0) | 56 (9.3) | 104 (17.3) |             |
| Marital status                 |                      |             |               |             |
| Single                         | 51 (8.5)             | 38 (6.3)    | 89 (14.8)     |             |
| Married                        | 227 (37.8)           | 183 (30.5)  | 410 (68.3)    |             |
| Separated/Divorced/Widowed     | 61 (10.2)            | 40 (6.7)    | 101 (16.9)    |             |
| Tribe                          |                      |             |               |             |
| Indigenes                      | 210 (35.0)           | 103 (17.2)  | 313 (52.2)    |             |
| Others                         | 129 (21.5)           | 158 (26.3)  | 287 (47.8)    |             |
Table 2. Attitude and sexual behaviours of respondents

| Variables                                      | Subjects                          | Males n (%) | Females n (%) | X²  | P-value |
|------------------------------------------------|-----------------------------------|-------------|---------------|-----|---------|
| Yes                                            |                                   | 279 (46.5)  | 214 (35.7)    | 0.010 | 0.992   |
| No                                             |                                   | 60 (10.0)   | 47 (7.8)      |      |         |
| **Perceived causes of HIV/AIDS**               |                                   |             |               |     |         |
| Witchcraft                                     |                                   | 73 (12.2)   | 58 (9.7)      |      |         |
| Evil spirit                                     |                                   | 51 (8.5)    | 42 (7.0)      | 0.207 | 0.902   |
| Biological (HIV virus)                         |                                   | 215 (35.8)  | 161 (26.8)    |      |         |
| **Mode of contact of HIV virus**               |                                   |             |               |     |         |
| Sexual intercourse                             |                                   | 47 (7.8)    | 44 (7.3)      |      |         |
| Cont. with bld. product (e.g. transfusion)     |                                   | 33 (5.5)    | 31 (5.2)      |      |         |
| Kissing                                        |                                   | 29 (4.8)    | 17 (2.8)      | 2.820 | 0.728   |
| Mosquito bite                                  |                                   | 89 (14.8)   | 70 (11.7)     |      |         |
| Hand shake                                     |                                   | 67 (11.2)   | 47 (7.8)      |      |         |
| Sharing personal items (spoon, towel etc)     |                                   | 74 (12.3)   | 52 (8.7)      |      |         |
| **Preferred sexual orientation**               |                                   |             |               |     |         |
| Man to woman                                   |                                   | 332 (55.3)  | 229 (38.2)    |      |         |
| Man to man                                     |                                   | 7 (1.2)     | -             | 25.223 | 0.001* |
| Woman to woman                                 |                                   | 32 (5.3)    | -             |      |         |
| **Frequency of sex with partner**              |                                   |             |               |     |         |
| Once a week                                    |                                   | 77 (12.8)   | 81 (13.5)     |      |         |
| 2-4 times a week                               |                                   | 123 (20.5)  | 69 (11.5)     | 8.561 | 0.073   |
| Two weekly                                     |                                   | 75 (12.5)   | 53 (8.8)      |      |         |
| Monthly                                        |                                   | 53 (8.8)    | 37 (6.2)      |      |         |
| Occasionally                                   |                                   | 31 (5.2)    | 21 (3.5)      |      |         |
| **Number of sexual Partners**                  |                                   |             |               |     |         |
| 1                                              |                                   | 173 (28.3)  | 169 (28.2)    | 11.813 | 0.003* |
| 2                                              |                                   | 97 (16.2)   | 58 (9.7)      |      |         |
| ≥3                                             |                                   | 69 (11.5)   | 34 (5.7)      |      |         |
| **Use of condom**                              |                                   |             |               |     |         |
| Yes                                            |                                   | 229 (38.2)  | 187 (31.2)    |      |         |
| No                                             |                                   | 83 (13.8)   | 65 (10.8)     | 5.381 | 0.068   |
| No response                                    |                                   | 27 (4.5)    | 9 (1.5)       |      |         |
| **Reaction to sex after +ve test**             |                                   |             |               |     |         |
| No change                                      |                                   | 38 (6.3)    | 23 (3.8)      |      |         |
| Abstinence                                     |                                   | 169 (28.2)  | 104 (17.3)    | 9.563 | 0.023*  |
| Always demand use of condom                    |                                   | 75 (12.5)   | 81 (13.5)     |      |         |
| Break-up relationship                          |                                   | 57 (9.5)    | 53 (8.8)      |      |         |  
| **Urge for sex after pt. had tested +ve**      |                                   |             |               |     |         |
| Always high                                    |                                   | 17 (2.8)    | 19 (3.2)      |      |         |
| Sometimes high                                 |                                   | 29 (4.8)    | 35 (5.8)      | 28.804 | 0.001* |
| No more                                        |                                   | 272 (45.3)  | 161 (26.8)    |      |         |
| No response                                    |                                   | 21 (3.5)    | 46 (7.7)      |      |         |
| **Frequency of anal sex**                      |                                   |             |               |     |         |
| Always                                         |                                   | -           | -             | 0.748 | 0.688   |
| Sometimes                                      |                                   | 11 (1.8)    | 9 (1.5)       |      |         |
| Occasionally                                    |                                   | 33 (5.5)    | 31 (5.2)      |      |         |
| Not at all                                      |                                   | 295 (49.2)  | 221 (36.8)    |      |         |
| **Willingness to undergo test after Patient had tested +ve** |               |             |               |     |         |
| Agreed                                         |                                   | 239 (39.8)  | 171 (28.5)    | 4.520 | 0.104   |
| Never agreed                                   |                                   | 93 (15.5)   | 77 (18.8)     |      |         |
| No response                                    |                                   | 7 (1.2)     | 13 (2.2)      |      |         |

*Statistically significant; pt=partner; bld.=blood; +ve=positive
A total of 229 (38.2%) males and 187 (31.2%) females used condom; 83 (13.8%) males and 65 (10.8%) refused it (X²=5.381; p=0.068). The urge for sexual intercourse was always high in 46 (7.7%) males and 54 (9.0%) females (X²=28.804; p=0.001). There reaction to sex was significant after partner had tested positive 38 (6.3%) males and 23 (3.8%) females had no change in attitude; 169 (28.2%) males and 104 (17.3%) females abstained from sex; while 75 (12.5%) and 81 (13.5%) would always demand use of condom during sex, but 57 (9.5%) males and 53 (8.8%) broke up the relationship. Anal sex was practiced by 44 (7.3%) males and 40 (6.7%) females (X²=9.563; p=0.002). A total of 239 (39.8%) males and 171 (28.5%) females were willing to undergo testing; while 93 (15.5%) and 77 (18.8%) respectively refused (X²=4.520; p=0.104).

Table 3 illustrates the health care seeking behaviours and reasons for choice of care. Two hundred and fifteen (35.8%) participants would prefer spirituality/prayers; 224 (37.3%) native/traditional care; while only 161 agreed on conventional method of care.

The participants chose various methods of care for different reasons. For easy affordability and accessibility, a total of 312 (52.0%) took to spirituality/prayers; 188 (31.3%) to native/traditional; while 100 (16.7%) to conventional care. Confidentiality was the main reason why 199 (33.1%) participants preferred spirituality/prayers; 328 (54.7%) native/traditional care and only 73 (12.2%) desired conventional care. On efficacy and better outcome, 223 (37.1%) participants embraced spirituality/prayers; 230 (38.3%) to native/traditional care; while 147 (24.5%) claimed to conventional care is efficacious and has a better outcome. A total of 206 (61.0%) participants believed the while rendering help to the affected individuals, the possibility of contracting HIV virus is high; 173 (28.8%) claimed it is low; while 61 (10.2%) did not believed they could be infected with HIV virus while helping infected persons.

4. DISCUSSION

This cross-sectional study investigated the sexual behaviours and attitudes, as well as HIV-healthcare seeking behaviours of Okposo fishing community in Akwa Ibom State. Although this study shows a high degree of awareness of existence of HIV/AIDS among

| Variables                                  | Subjects |
|--------------------------------------------|----------|
| Preferred method of care                   |          |
| Spiritual/Prayers                          | Male sn (%) | Female sn (%) | Total n (%) |
|                                            | 114 (19.0) | 101 (16.8) | 215 (35.8) |
| Native/Traditional care                    | 131 (21.8) | 93 (15.5) | 224 (37.3) |
| Conventional care                          | 94 (15.7) | 67 (11.2) | 161 (26.9) |
| Affordability/Accessibility                |          |
| Spiritual/Prayers                          | 178 (29.7) | 134 (22.3) | 312 (52.0) |
| Native/Traditional care                    | 107 (17.8) | 81 (13.5) | 188 (31.3) |
| Conventional care                          | 54 (9.0) | 46 (7.7) | 100 (16.7) |
| Confidentiality                            |          |
| Spiritual/Prayers                          | 101 (16.8) | 98 (16.3) | 199 (33.1) |
| Native/Traditional care                    | 205 (34.2) | 123 (20.5) | 328 (54.7) |
| Conventional care                          | 33 (5.5) | 40 (6.7) | 73 (12.2) |
| Efficacy & Better Outcome                  |          |
| Spiritual/Prayers                          | 119 (19.8) | 104 (17.3) | 223 (37.1) |
| Native/Traditional care                    | 132 (22.0) | 98 (16.3) | 230 (38.3) |
| Conventional care                          | 88 (14.7) | 59 (9.8) | 147 (24.5) |
| Possibility of contracting HIV virus in course of rendering care |          |
| Very high                                  | 109 (18.2) | 97 (16.2) | 206 (34.3) |
| High                                       | 91 (15.2) | 69 (11.5) | 160 (26.7) |
| Low                                        | 64 (10.7) | 43 (7.2) | 107 (17.8) |
| Very low                                   | 48 (8.0) | 18 (3.0) | 66 (11.0) |
| Not at all                                 | 27 (4.5) | 34 (5.7) | 61 (10.2) |
the participants as in previous studies [18,23,24] the fact that 10% of males and 8% females still lacked awareness is significant. This together with the erroneous perception of the cause of HIV/AIDS among the people could have wider implications in a country like Nigeria whose population is being dominated by youths and young adults within the ages of 15-45 years. Given that risky sexual behaviour is common among this age group, the control and prevention of HIV/AIDS in the fishing areas could be a major problem. Therefore, a lot still need to be done with respect to continuous enlightenment and lifestyle modification, if efforts aimed at taming the spread of HIV/AIDS are to yield positive results. This is because sexual contact with the infected persons still remains the most frequent mode of transmission of HIV virus [23,25,26].

In line with previous studies, the findings of this study seem to corroborate the basic sociodemographic characteristics of people likely to be affected with HIV/AIDS [23,27-29]. Majority of the participants in this study were between 18 and 41 years of age. This is the age group that is sexually active and vulnerable to HIV/AIDS because of high risk taking behaviours [30-33]. The involvement of this potent workforce could have a significant impact on economic growth and development. This is because HIV/AIDS is widely reported to affect mostly the young people and thereby reducing the gross domestic product of many countries due to lack of human capital [5,28]. The sociodemographic profile of the participants in this study also reveals that 20% of them had no source of income and 15% were not married. Although, it may be difficult to justify the influence of marriage on the control of HIV/AIDS, however, the attitude of the participants with respect to sexual intercourse is worrisome. The findings seem to suggest that the participants had a high urge for sex. The wish to survive and the lack of visible means of livelihood, especially among those with marital difficulties could act as major factors dragging them into prostitution. This alone could further impact negatively on the control of HIV/AIDS in the communities. It is also important to emphasize that there is a positive development in this study. Despite the fact that 26% of the participants had no formal education, the knowledge of the existence of HIV/AIDS was high. However, more still need to be done because it is frightening to note that many of them still attribute HIV/AIDS to non-existent factors. This is dangerous and has the tendency to affect the quality of care.

The concern about the increasing prevalence of HIV/AIDS in the fishing communities is the central purpose of this study. Anecdotal reports from general observations and surveys have shown that the high incidence in these areas is attributable to the sexual attitude and behaviours of the people [13,27,34]. The findings reported here indicate that some of these attitude and behaviours are inimical and seem to promote the spread and transmission of HIV/AIDS in the fishing communities. For example, about 25% of the participants would not use condom during sexual intercourse. Although no possible reasons were proffered for not taking this preventive measure during sex, it may not be unconnected with the ignorance and indifference to the consequences of the risk involved. This could be serious in view of the unprecedented urge for sex already reported in 17% of the participants. The implications could be enormous, given that a significant percent of the participants in this study have two or more sexual partners. Evidence from previous studies has shown that unprotected heterosexual intercourse is the commonest route of HIV infections [13,23,35]. There is also overwhelming evidence that the risk of transmission of HIV/AIDS increases with multiple sexual partners [36-39]. Therefore, the implication could be overwhelming in an area where people are often not willing to disclose their HIV status. More importantly, because of the climatic conditions of these coaster areas and the nature of their occupation, many of them are often indulged in psychoactive substance use to fight cold and for perceived strength. This could further affect their sexual attitude and/or behaviour. Two things could be possible; more people would be at the risk of contracting HIV infections. And secondly, the immense benefits often derived from HIV counseling and testing may not be feasible. To reverse this awkward trend of HIV/AIDS scourge in the riverine areas with difficult terrain, the findings of this study seem to provide further support for the need for lifestyle modification. This may be achieved through sustained massive education campaigns targeted on young men and women, for purposes of eliminating possible obstacles and difficulties in instituting appropriate control strategies. Studies have shown that the young age group is the most vulnerable and this constitutes about 60% of the people living with HIV/AIDS (PLWHA) globally [40,41].

Another major finding from this study is the purported mode of contracting HIV/AIDS by the participants. Majority of them still believed that
HIV/AIDS can be acquired either through mosquito bites, handshakes or sharing personal items like spoons, towels and clothes. This is misleading and could have a wide range of social and economic implications. One major concern would be the issue of stigma and discrimination. This could affect the quality of care given to the people living HIV/AIDS. HIV is widely reported to be transmitted by three main routes: sexual contact, exposure to infected body fluids or tissues and from mother to child during pregnancy, delivery, or breast feeding (known as vertical transmission) [40]. Therefore, to have an impression that HIV can be contracted through other routes or ways, is erroneous and is borne out of ignorance. Evidence has shown that there is no risk of acquiring HIV, if exposed to feces, nasal secretions, saliva, sputum, sweat, tears, urine or vomit unless these are contaminated with blood [41]. However, it is possible to be co-infected by more than one strain of HIV-a condition known as HIV superinfection [42]. The purported impression may further affect the possibility of evaluating the impact of HIV/AIDS in many of these areas.

In this study, it is important to look at some the attitudes critically, as well as the reasons for preferring different methods of care reported here in Table 3. The implication is that some of these attitudes have the tendency to reverse the progress made in the fight against HIV/AIDS. This is important especially in rural communities where adequate information on sexual health is lacking. There is also a revelation that that anal sex is also being practiced by the people in the fishing communities. Although the rate is not high as in other studies outside Nigeria [43], it is very significant because of the risk of spread and transmission of HIV infection. Evidence from previous studies have shown that approximately between 1.4-1.7% HIV infection result from anal intercourse per act in both heterosexual and homosexual contacts [16,23]. This may impact negatively on the efforts to control the spread of HIV/AIDS in the State as a whole, given that trading is one of the main occupations of the people in this area. It is needful to emphasize that fish is an important delicacy not only for the people in the fishing communities, but the entire country. Some of the participants are traders. Their routine movements in and out in course of their business make them to socially and intimately interact with other people. Therefore, there is need to embark on strategies aimed at increasing awareness and aggressive change in lifestyle including voluntary testing and counseling. One important benefit that could be derived from this is a better understanding of the disease and a yearning for prevention and control through abeyance.

Our study also demonstrates the possible treatment channels that may be engaged by the participants in caring for people living with HIV/AIDS in the fishing communities. Although, this may depend to a large extent on the culture and perceived cause of illness, the findings from this study seem to suggest that several factors influence the pathways to care. Some of these factors as highlighted in this study include availability or absence of the health facilities, easy accessibility and affordability, perceived efficacy and outcome. However, two reasons proffered by the participants need to be looked at critically, in order to encourage people to seek for adequate care. One of them is confidentiality. This is very important because people usually tend to harbor fears of their problems being divulged to the public. Studies have shown that native/traditional care is preferred by many people not only because of its perceived efficacy, but is more secretive [44,45]. Therefore, it is not surprising that a greater percentage of participants in this study (54%) and (33%) preferred native/traditional care and spiritual/prayers respectively, because of confidentiality. The loss of confidence in conventional care might not be unconnected with the way and manner it is being practiced. Information gathering and investigations are part and parcel of the practice. These are always required before treatments are offered. They are often thought to be the processes through which peoples’ problems might be exposed to others. Therefore, there is need to build and instill confidence in the people during modern care.

One other significant finding from this study is the erroneous perception that taking care of people living with HIV/AIDS can result in contracting HIV infection. This impression is dangerous and needs to be corrected because of the possible implication of depriving people living the virus the needed care. The absence of social security and depreciating standard of health care facilities and services in many developing countries including Nigeria, seem to impose the burden of care on the significant others. Therefore, the quality of care rendered would depend on the attitude and health care seeking behaviour of the caregivers. This is more so since nature and chronicity of the HIV infection makes it very difficult for the affected individuals to make decisions
concerning their own care. As is reported in this study, only 10% of the participants were found to be willing to render care to their sick relatives or partners. This seems to suggest that majority of the people living with HIV/AIDS in the fishing communities would never get the needed care. This could have wider implications on the quality of life of people living with the disease, leading to increased morbidity and mortality.

The limitations of this study lies in the fact it is a self report and is bound to be biased. It is very difficult to have genuine and true information from people concerning their social life including sexual attitudes and behaviours. The results of this study cannot be generalized because it was not possible to assess the entire people living in the fishing communities due to difficult terrain. A more robust study with larger sample size that will cover many fishing communities is recommended in order to generalize such a result.

5. CONCLUSION

In conclusion, the findings of this study suggest that attitude and lifestyle may be the major factors contributing to the upsurge of HIV/AIDS prevalence in the riverine and coastal areas Nigeria. The implication is that no matter how remote these areas may be, because of the day-to-day human interactions, the general public still stands the risk of experiencing the adverse impact of HIV/AIDS. Therefore, efforts must be made to redouble the energy and commitment to community mobilization and campaigns aimed increasing awareness. The great optimism of winning the fight against HIV/AIDS must be sustained by eliminating cultural obstacles and erroneous perception that seem to create the gaps in understanding the disease. There is also need for the provision and equipping of health facilities to encourage those with problem the opportunity for adequate medical. These facilities will also be used in sustaining the campaigns and promoting the distribution of antiretroviral medications to the affected individuals.

Recognizing that the social and economic indices are central to the spread of HIV virus, there is need for socioeconomic empowerment of the people. This apart from checkmating the upsurge of HIV/AIDS in the fishing communities will also enable the people to have access and afford modern care. Nigeria, like many other African cultures is full of beliefs and perceptions on supernatural deities. Even among the highly educated, almost all illnesses are attributable to ancestors, evil spirits or witchcrafts. There is need to dispel these beliefs and primitive perceptions on the causes of illness including HIV/AIDS if quality care must be guaranteed. One way of doing this is through sustained and continued health education.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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