28. Socio-cultural relations in the Nigerian family: implications for AIDS in Africa [1]

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Introduction

In the mid-1980s when the acquired immune deficiency syndrome (AIDS) was first heard of in this part of Africa, many Nigerians and even health professionals referred to it derisively as 'American Invention to Destroy Sex'. Little did we realise then that we were starting to deal with a disease which would spread like wild wood fire and defy all cures (Lamptey 1994). Perhaps the most important epidemiological finding about AIDS is that sexual transmission accounts for about three-fifths of HIV infections worldwide. Even though parental transmission (blood and injections) plays a key role in the spread of HIV in some countries, it is not a major factor in driving the pandemic.

The link between HIV infection and other STDs may partly explain why HIV in heterosexual population is more prevalent in Africa than in Europe and the United States of America, where STDs are more often treated and cured. We have also learnt that women are particularly vulnerable to AIDS and that prevention programs must address their special needs (Henry 1994). The major factors that put women at risk of HIV infection are social and economic, such as poverty, gender discrimination, lack of power in negotiating sex (Oyekanmi 1994) and lack of educational and economic opportunities. The prevalence of HIV infection in Africa is highest in the 25-35 years old age-group in males, and in the 15-25 years old age-group in females. This difference is due to the fact that on the average, sexual partnerships are formed between older men and younger women. In the urban areas the distorsion of population profile caused by male migration may give a 1: 1 ratio of male: female HIV infection rate, but as the epidemic spread into the larger rural population, the absolute size of the most severely affected young female population is larger than the size of the male population, which eventually results in a higher number of infections in women.

The infection of women also adds fuel to the emerging epidemic of pediatric AIDS (Decosas and Pedneault 1992). Babies born to the

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infected women would be affected either at birth or through breast feeding. Several public health policies have been suggested to narrow the male: female age-gap of sexual partnership formation, as well as policies to address the economic migration of the male and female work force; and policies to narrow the base of the general population pyramid. AIDS and STD specialists tend to ignore the fact that the future-at-risk generation has already been born. For example, in Nigeria about 45 percent of the population is of age 0-14 years. Even if the incidence rates of HIV infections stabilises, the absolute number of cases will still continue to grow, driven by demographic forces. This trend will continue and it may well outpace any possible health programme response unless it is reversed by a decrease in fertility. An effective population policy is thus one of three imperatives for addressing the social and demographic risk factors associated with AIDS in this country as in the rest of Africa. The other two public policy areas are an effective gender and education policy and a family-friendly industrial and economic development policy.

To enable individuals to sustain behaviour change, we need to address community and societal factors, policies and structural issues that influence and shape behaviour. The most important risk-taking behaviours that are primarily responsible for the rapid spread of HIV throughout the world include frequent change of sex partners, and sex with a partner who has mutiple partners. Thus as social scientists, we need to take a look at the socio-cultural factors and cultural expectations that shape behaviour. The family being the primary unit of any society assumes a prime position in this context.

Forms of family and marriage

Our cultural practices exert direct and indirect influences on our population dynamics. By population dynamics we mean those aspects of our lives which have consequencies for mortality (as well as morbidity), fertility and migration —all three of which constitute the main components of population change. These in turn have bearing on the issues concerning HIV/AIDS in any country.

What do we mean by culture? As defined by Edward Taylor, culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of the society (Olurode 1989). It means that culture is the totality of living. Some basic characteristics of culture include the following: culture is shared, it is learned and not genetically transformed. Cultural traits, mode of behaviour are learned through the process of socialisation in a society.

These cultural traits are usually learned within the family. In fact the family is the smallest unit of organisation within the society; much akin to the atom in science.

It has been generally noted that what constitutes the family varies from society to society. Various definitions include the nuclear family,

the extended family, and so on. Various traits are usually observed when the definition of a family is being undertaken. These include:
• family type: joint / extended
• marriage type: monogyny / polygyny / polyandry
• residence arrangement: unilocal / matrilocal / patrilocal
• life cycle or stage of the family
• inheritance system - property, widowhood
• marriage ceremony - customary / ordinance / religious.

Other traits which could influence the behaviour of members of the family include:
• value of child: child bearing practices / quality of child / preference for sex of child
• gender relations in the family: culture as regards relationship between couples, relationship to persons who are neither biological nor affilial kin / level of development / status of women / female autonomy / male dominance / education, etc.
• health care pratices and services
• family planning methods: knowledge, attitude and practice / use / availability and cost of family planning services / information, education and communication/population policy.

The structure or type of a family is usually defined in terms of the individuals comprising the family unit as well as the relationships / interactions among these members.

The family is a group of people recognised by their community as related to one another by ties of marriage. The members are bound together by relationships involved in living together. Usually the group is composed of a man and his wife or wives and their children. At its simplest form, the nuclear or conjugal family is a married couple and their children (Bloom and Ottong 1987) as shown in figures 1A and 1B.

Figure 1A: *A typical nuclear family, a husband, wife and four children. Nuclear family (monogamous)*

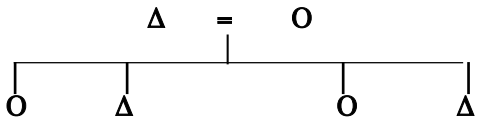
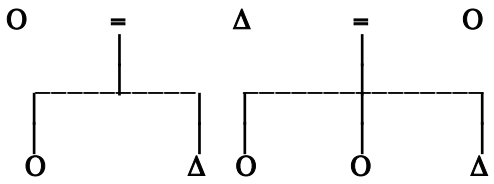


Figure 1B: *Husband, two wives and their children Nuclear family (polygamous)*



Key: Δ: Male; O: Female; = : Marriage

This is the simplest form of family. In real life there may be variations. In some families there may be adopted children. Sometimes the household may include relatives of the wife or the husband. The conjugal relationship between spouses is the major link in the nuclear family. The nuclear family is more predominant in the European and other Western cultures.

Much more common in Africa is the extended family. This is a family composed of two or more nuclear families, joined either through the line of parents and children, or by relationships between siblings. The extended family goes beyond the mother-father-children to include other relatives. It frequently spans three generations - grandparents, parents and grand children as shown in figures 2A and 2B.

Figure 2A*: Monogamous unions in extended family formation*

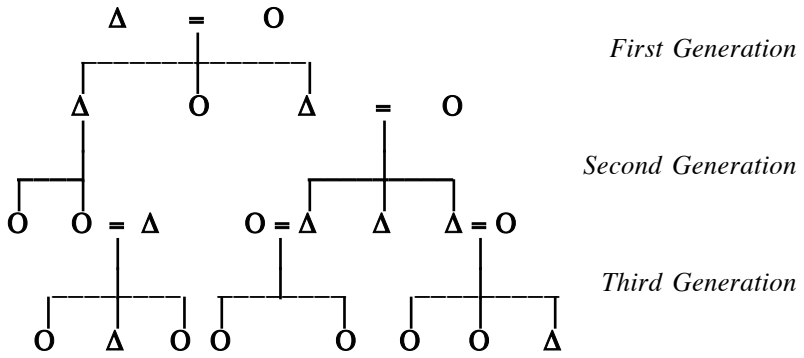
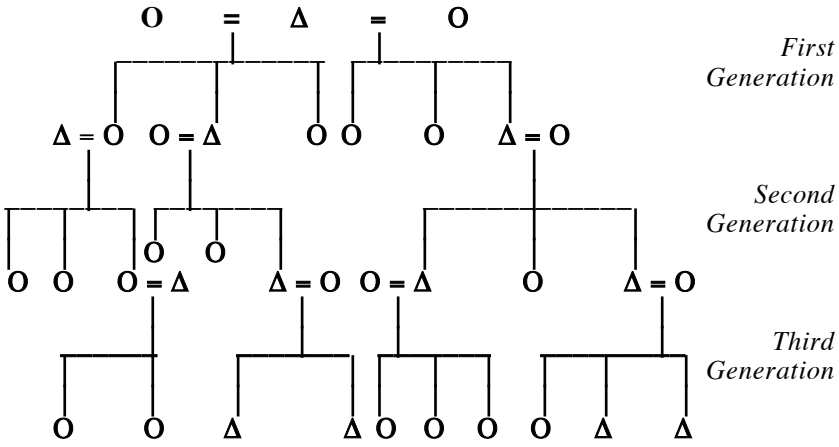


Figure 2B: *Polygamous unions in extended family formation*



Not all the members of the extended family live together in one household. In many instances, the extended family is split into smaller nuclear units, each with its own household within a compound. The summation of all the family units make up the community/society.

Sexual relations

Variations do occur in the actual sexual relations within families depending on the culture of the society concerned. For example among the Masai of Northern Kenya a woman is recognised as being married to a particular man within a lineage. However, other men within the lineage can come to her for sex at any time that her husband is away hunting or tending to cattle. This ensures that during the long stretches of time that these nomadic herdsmen are away from home, the wives are served sexually by the husband's kinsmen in a way that would maximise fertility performance. The man cohabiting with the woman at any time puts his spear into the ground in front of the woman's residential hut.

Furthermore upon return from the long sojourn away from home, the husband of the particular woman keeps away from the hut where the woman resides as long as there is another man's spear stuck in the ground in front of the hut. If the woman gets pregnant the offspring belongs to the clan/lineage so there is no question about the paternity of the child.

Another pattern has been cited among some groups in Uganda where the burial rites performed on the demise of a husband includes the purification/cleansing of his wife. Such cleansing consists of the junior brother of the deceased man sleeping with the widow and having sex with her on the night her husband is buried so as to exorcise the latter's ghost.

In Nigeria, among the Yagba of the middle belt area, there exists a custom whereby the height of a man showing his friendship to another man is for the former to give his wife to the latter to sleep with her as a mark of the closeness of their relationship. No connotation of adultery is attached to such sexual liaison because sleeping with such a wife is regarded as a way of strenghtening the men's friendship.

From the point of view of likely proliferation of sexually transmitted diseases we see that the above traditional practises in Kenya, Uganda and even the polygyny or emerging serial monogamy in Nigeria are very potentially dangerous. This is because if any single HIV positive person is within the ring of sexually networking people then the disease transmission is more or less 100 percent assured.

The succeeding sections would go on to elaborate in detail how other socio-cultural factors related to the family can affect or be affected by the HIV/AIDS pandemic.

Condom use

Although, endowed with great human and natural resource potentials, Nigeria, with a persisting high population growth rate, an infant mortality rate of about 84 percent live births, life expectancy at birth of about 54 years, a per capita income of less than US$300, poorly developed systems of education, medical and social services is still one of the world's poor and under developed countries.

The 1990 Nigeria Demographic and Health Survey shows that total fertility rate in Nigeria was 6.0. Similarly the 1991 Post Enumeration Survey after the national population census showed that the total fertility rate was 5.88 and that a woman would bear 6 children at the end of her reproductive career. While the crude birth rate was estimated at 45 births per 1000 population in the country in 1991.

The AIDS pandemic has brought into sharp focus the issue surrounding usage of condom in Nigeria; not only for reproductive health but to stem the transmission of HIV/AIDS.

In Nigeria the Information, Education and Communication (IEC) Committee of the National AIDS Control Programme has mounted a vigorous nation-wide mass-media campaign to inform and educate the Nigerian public on the dangers of AIDS, and the need to adopt 'safer sex' measures by regular use of condoms. As shown in table 1, the rate of condom use in Nigeria is still low (Obikeze *et al*. 1993) with 9.2 percent ever-use and 2.6 percent current use by male and female.

Table 1: *Ever-use condom data from NDHS (1990), DHS Ondo State (1986), and Condom Use Survey (1991)*

Source	*Year*	*Coverage*	*% Ever-Use Condom*	
			Females only	Both male and female
NDH Survey [a]	1990	Nigeria	2.5	-
DHS Ondo State	1986	Ondo State	4.4	-
Condom Use Survey	1991	Three States:		
		Anambra State	5.5	7.6
		Kaduna State	4.9	6.2
		Lagos State	13.6	15.1
		Overall (National)	8.5	9.2

Source: Obikeze *et al*. 1993, table 4.17

[a] = covered women of child bearing age.

But this figure is significantly higher than the 2.5 percent ever-use reported by the Nigeria Demographic and Health Survey (NDHS 1990). The challenge remains how to popularise the use of this reproductive health device in not only Nigeria but also in West Africa.

Although the financial cost (economic) of the condom is moderate and generally affordable, the social and psychological costs of obtaining and being associated with the condom are very high and prohibitive. Six major reasons for non use of condom are (1) misconceptions due to misinformation and ignorance, (2) inherent poor public image and old prejudices, (3) high breakage and failure rate of available condoms, (4) incompatibility with traditional sexual norms and practices, (5) high social and psychological costs associated with condom procurement and use, (6) disapproval by the major religions in the country. For example, as explained by Obikeze *et al.* (1993), the perceived availability of the condom comprises three distinct components, namely: product visibility, physical (de facto) presence, and affordability in terms of both economic and social costs. As one focus group discussant dramatically put it, persons involved in condom transaction tend to 'speak in tongues' using slang known to buyers and sellers. Low level of education was also shown to be strongly associated with negative user-acceptability of the condom.

Socio-cultural practices

The issue of power relations within the family has been much studied in different cultures. For most of the language / tribal groups in Nigeria, the husband is assumed to be the head of the household. He dictates what gets done in the family including when he has sex with his wife or wives. It is therefore inconceivable to think of a situation where the wife would refuse to grant sexual favours to her husband on demand. The woman can also not insist on the man using condom or any other protective device while having sex with her without incurring the wrath of the man. This powerlessness of the woman to negotiate conditions favouring her is even made worse if she is an illiterate, poor, and rural dweller.

The economic dominance of the male gender is such that the man's sexual relations within the family or his extra-marital affairs can endanger the health of his wife or wives without any sanction being imposed on the man (Odebiyi 1992). Odebiyi has also shown that even male undergraduate students at University of Ife though aware of the danger of AIDS, nevertheless did not favour the use of condoms. The pilot study done by Oyekanmi in Ilesa, Oshun State in 1991 (Oyekanmi 1994b) also showed this unwillingness of the men to use condom. Moreover the married women felt that even if their husbands contract any sexually transmitted disease God would not allow the wives to catch it from them. This extreme positivism has been developed in many cultures as a means of wishing away whatever bad phenomenom that we cannot control, women in particular seem to have developed this defence mechanism to a larger extent than the men.

The gender inequality in decision taking also bothers on the question of who takes decisions about health care in the family. In a large percentage of cases it is the woman who first notices if anybody is not feeling well. At home women are usually the first to be told

when someone does not feel well, and they help to decide what to do next. Most "patient" communications for and about family members flow through women; they report signs and changes, symptoms, responses to treatments and medications. It is little wonder that single or divorced men tend to have higher mortality rates than married males (Oyekanmi 1994a). However, in cases where expenses have to be incurred in order to procure a cure to any disease the woman has to defer to the husband's opinion. If the husband therefore does not adjudge the situation to be a serious problem no health care service would be sought in time to avert a disaster. In the particular case of sexually transmitted diseases including AIDS we are dealing with an issue concerned with sexuality and therefore ego factors of the male. In such cases, changes in behaviour, would be more difficult to effect. Moreover, fears for acceptance of guilt in a particular individual may cause people not to report symptoms in time. Over time experience has shown that changes come slowly, especially where issues concerned are intertwined with customs or religion and tread on vested interests (Corea 1985).

Some of our traditional practices that may have an effect on HIV transmission include circumcision of male and female newborn babies, tattoo and other tribal marks and shaving of hair with unsterilised blades. Among the Igbo a person's hair is completely shaved if he or she loses a parent irrespective of age. Moreover as part of burial rites for a deceased husband, the wife's hair is shaved.

Where these various traditional chores are done by traditional birth attendants e.g. cutting of the umbilical cord or circumcision of a newborn baby with unsterilised instruments, it is quite possible to pass on the HIV virus from one person to another. Since the incubation period for full-blown AIDS is about 10 years, one can quite imagine the number of people who can plausibly get infected in this manner.

In some cases the traditional herbalists associate AIDS with *'magun'* (Odebiyi 1992). In Yorubaland '*magun*' is a disease which is caught through having illegal sexual intercourse with any woman who has been laced with poison by her suspicious husband. The husband carefully avoids having sex with the woman after the poisoning and any man who first has sex with her subsequently is believed to catch '*magun*', the symptoms of which include jumping thrice or crowing like a cock thrice before the man falls down dead immediately. So far the antidote for '*magun*' is known only to so few herbalists that the affliction is said to have no cure. Thus men are advised to keep away from illegal sexual liaisons with women whose husbands are suspected to be wicked/jealous enough to administer such poison on their wives. Nevertheless it is noteworthy that even the few herbalists who claim to be able to cure '*magun*' have not cured any known AIDS patient.

The cultural practice of marrying girls at very tender ages —sometimes at 12 years or younger— to older men, for example among the Hausa-Fulani of Northern Nigeria and adherents of the Islamic religions, is also taught to be fraught with danger. Trevor (1975) estimated that between ages 13 and menopause the average Hausa/Fulani girl would contract three marriages. And even after menopause she is

likely to contract one additional marriage, if only for economic survival. This implies a high rate of sexual partnership and may even encourage promiscuity among the females, with the attendant danger of STD transmission. In some cases control of sexuality among members of a particular family may be difficult, especially where there is a wide age gap between husband and wife. In a study in Ado Ekiti, Ondo State, Orubuloye (1993) has found that adult sons sometimes sleep with the young wives of their elderly fathers. The other members of the family even know about these events but keep quiet out of the fear of incurring the anger of their father.

The national population policy in Nigeria recommends that each woman should have four children; while each man is advised to have a 'limited' number of wives and bear the number of children whom he can cater for responsibly (Oyekanmi and Aig-Imoukhuede 1989). So we see that even at the official governmental level there is tacit permission for sexual promiscuity among men and for high fertility in the country in general. Given the prevailing broad based population pyramid in Nigeria with about 45 percent of population being aged 0 to 14 years, as well as the prevailing high fertility levels whereby each woman has an average of 6.4 children in her life time, one cannot help but worry about the implications of the possibility of the AIDS virus being passed from mother to child. In effect pediatric AIDS —both its occurrence and spread— should begin to be of great concern to all the relevant disciplines and planners. In Rwanda, for example, 33 percent of women registering for antenatal clinics are being found to be HIV positive.

High-risk behaviour

While there are some professions which have been recognised as high-risk ones in connection with the transmission of the HIV virus, other imported cultural practices need to be looked at critically. The practices which are believed to be imported into Nigeria include homosexuality (Oyekanmi 1994b), lesbianism, wife swapping (Orubuloye 1993). The high risk occupations include long distance driving, prostitution or commercial sex work, itinerant trading especially those selling food and drink at motor parks, international traders who go from one country to another within the West African subregion and beyond in order to buy and sell goods and services (Anarfi 1992). Even members of the armed forces, police and prisons who get transferred frequently in the course of their duties and often separated from their families are also high risk.

For the most part men who patronise prostitutes do not want to use condoms because they complain that the device diminishes the sexual enjoyment and some who agree to use the device even refuse to pay up the whole charged price after the contact since they claim that they did not have 'full servicing' because of the condom.

Studies of condom use in Nigeria have also shown that age is a significant determining factor in the usage of condom, despite the

knowledge or awareness of it as a protective device against unwanted pregnancies or transmission of STD. Ogionwo and Ademuwagun (1990) in their study of south-western Nigeria showed that age 40 seems to be a significant dividing line; percentages of respondents ever use of condom were 67.3 percent for respondents under 40 years as compared with 32.7 percent for respondents over 40 years in urban areas; compared with 75.4 percent for respondents below 40 years and 24.6 percent for respondents over 40 years in rural areas. Obikeze *et al*. (1993) also found that the rate of condom use is higher among youths than old people in a national survey of Nigeria. It would appear that the older people are more set in their habits than younger ones and therefore, more likely to resist modern methods of birth control or health care innovation generally.

The issue of sexual permissiveness, moral decadence and laxity has been an age long affair, which is, unfortunately, more pronounced in recent times. Premarital sexual intercourse was not only considered a taboo, the fear of not finding suitable husbands after being disvirgined prevented young ladies from yielding unnecessarily to sexual temptations in the olden days. Besides the fear of being exposed to the gods, adultery was also seriously avoided by women in order to prevent the ridicule and shame of being caught and to avoid sexually transmitted diseases, of which gonorrhea was the most widely known. The situation is no longer the same today due to urbanization, migration in search of jobs, influence of contact with other cultures, economic strangulation of most parents, especially since the structural adjustment programme (SAP) was introduced into this country in 1986 by the government at the advice of World Bank and IMF; the get rich quick syndrome among the youths and other socially destabilising factors. It has been observed that these days students in secondary schools and in tertiary institutions of learning are freelancing as commercial sex workers in some hotels and brothels.

Moreover prostitution is no longer the preserve of the female gender. Males are also selling sex for favour. Where these males happen to be bisexual —having sex with other males and also with female depending on the circumstances— the chances for proliferation of STDs and possibly AIDS are greatly increased.

The modern health care delivery systems in Nigeria is not able to cope with the demand. It is estimated that modern medical services cover about 40 percent of our populace, while the rest get catered for by medical auxiliaries, traditional birth attendants and even quacks. 'Wonder drugs' are sold freely in our various markets. Thus the issues of screening of blood before transfusion to patients needing operations, incisions and cuts with sterilised instruments —shortage of water supply even to medical establishments are not uncommon— treatment of infections including STDs are pertinent questions which should be raised here. As of now we do not have enough laboratory facilities to even confirm the prevalence of HIV positivity in this country. On some occasions the needed reagents are not available even in the designated screening centers. Generally, it seems as if succeeding government administrations have failed to devote enough

resources to health and social services in Nigeria. Furthermore the environmental sanitation, especially in the urban centers —over-crowding in homes, poor cleanliness in all surroundings, bad drainage, etc— can lead to the propagation of diseases like tuberculosis which have been associated with symptoms of AIDS/HIV infection.

In addition to the foregoing is the high cost of procuring medical prescriptions/drugs. These have been seen to lead to a lot of drug abuse and misuse. Antibiotics and other drugs which could be effective in treating bacterial infections are grossly misused with the result that they fail to cure patients when really needed. Moreover the use of hard drugs —marijuana, heroin, cocaine, etc.— is becoming alarming in our populace, especially among the unemployed youths and these have been known to influence character formation and behaviour patterns malevolently. Obviously a person who is already high on a mind-bending drug is most unlikely to adopt safe sexual or even other health enhancing practice. Thus efforts at educating people on AIDS prevention should also link up with drug-abuse campaigns. It is necessary to stress that as of now there is no known vaccine to prevent HIV infection. Neither is there a vaccine to cure those already infected with the HIV virus that causes AIDS.

Health implication of sexual behaviours

From the foregoing discussion it is necessary to note that AIDS for now has no known cure. What can Nigeria do therefore in order to ensure that the family as a basic unit of the society acts as a reinforcing factor to stem the tide of the AIDS pandemic in our country.

First, it is important to stress the importance of parents/child interactions. What do parents pass on to their children as information on sexuality? The earlier the facts of male-female relations are given to children in emotionally free atmosphere the better for the children. In most cases the children, especially the teenagers, tend to pick up half-truths and disinformation from their friends and peers at school and during social contacts. Hence parents need to closely monitor and also discuss with their adolescent children. Parents can also be encouraged to give consent to sex education being taught in schools.

In this line, parents should be discouraged from giving out their daughters for marriage at tender ages. The minimum age at first marriage is 18 years and 25 years for girls and boys respectively as recommended in our population policy. People should be advised to respect these. Presently even the so-called leaders in the country flout this advice without any sanction being imposed on them.

Childrearing practices such as fostering, child labour as hawkers, should be reexamined in order to stem cases of rape and incest in families. Also rape victims should be well treated to avoid risk of STD.

In case of marital break-ups after the first marriage, it is essential that family support be given to the individuals so affected. This is because experience has shown that women, especially the uneducated

and poor, tend to rush into subsequent marriages as an economic expediency, much to the danger of their mental and physical health.

Religious and cultural injunctions which have been used to reinforce high fertility as well as preference for male children in our societies need to be re-examined. Even the *Hadith* in the Islamic faith says that a man or woman that can raise three females to maturity, even where he/she cannot have a male child is assured of a place in paradise. Similarly the Bible although enjoying people to go into the world and multiply, also cautions people to raise only those children whom they can cater for appropriately. Hence the stress of having many children, particular fot a woman, should be discouraged if we are not to have excessive population as an obstruction to our economic and social development.

Related to this perhaps is the issue of old age security for people. Where AIDS kills off able-bodied adults and old grandparents or siblings are left to take care of children of AIDS victims, then, the society at large has to come to their rescue. One would recommend that social security scheme be set up by our government to take care of all destitutes. Anybody whose income from all sources fall below a certain minimum level prescribed should be entitled to draw upon certain funds. In this way the family members also do not have to bear the full burden of caring for children and dependents of AIDS victims. Moreover, since AIDS does not kill the victim immediately, funds are needed to maintain him/her while still alive. Women especially cannot abandon their husbands or children in case of such affliction and anything which can be done to lessen their problems would be welcome. Even for young families the prevailing economic circumstances are such that the permanent disability of one earner in a family can be almost disastrous for all. We are all finding it increasingly difficult to be our 'brother's keeper'. Furthermore there is need for a closer look at home-based care of AIDS victims.

For career women (professionals in the modern sector labour force, employees, traders, entrepreneurs in the informal sector), it is becoming glaring that mother substitutes, such as househelps, drivers, etc, are needed to work at home while the woman goes out to earn a living. As a result of this, problems are arising as to sexual relations between such workers and members of the family. Cases of rape or sexual molestation of housegirls by husbands of such career women (madam's husband or '*oga*') are surfacing in increasing numbers. In addition rape of madam's daughter by house boys or drivers have been heard of. Of course nobody hears of sexual contacts based on mutual consent. In any case, any of these instances leaves room for the propagation of sexually transmitted diseases including AIDS. Hence one would advise that career men and women should be extra careful about their household members and workers.

Conclusion

The policy implications of all the foregoing would indicate a multisectoral approach to the issue of AIDS in Nigeria. We have to involve the family, the school, the Ministry of Health and Social Services, the Ministry of Education for formal and informal awareness programmes, the National Drug Law Enforcement Agency, the Armed Forces, Police, Customs and the professionals like Sociologists, Psychologists, to study behavioural patterns and possibility of changes therein. We need to take a close look at what we can change in our culture to favour safe sexual habits. Look at gender power relations within the family so as to locate the focus of power and influence it. There is need for better population statistics in this country to enable us know how many people we are dealing with and plan for them adequately. To this end one would advise that there should no longer be any cancellation of any census in this country.[1]

Reproductive health and family planning services should be given more attention by the health providers. Proper screening of any blood to be transfused must be stressed. The involvement of non-governmental organisations, voluntary associations, and multinational bodies are needed here to complement the efforts of our government. Nigeria should endeavour to disseminate more information on its AIDS Programme through such avenues as the mass media, conferences, seminars, etc., both within the country and internationally. We can thereby solicit for more resources for our national AIDS Programme.

Finally, in addition to general information, education and communication (IEC) programmes to generate awareness of AIDS in our populace as is done in marking the World AIDS day, it is imperative that special programmes be designed for specific groups like commercial sex workers, long distance drivers, adolescents in and out of school, institutional populations who are not normally covered in social surveys, married men and women, traditional leaders, and community opinion leaders and so on. We should not assume that any individual is too small or too important to be approached. We should stress that AIDS has no boundary.

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[1] Note that the 1991 population census figures were finally accepted by the government authorities in 1997.

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Felicia A. Durojaiye OYEKANMI, *Socio-cultural relations in the Nigerian family: implications for AIDS in Africa*

Summary — In Africa, women are particularly vulnerable to AIDS and the major factors putting women at high risk of HIV infection are social and economic such as poverty, gender discrimination, lack of power in negotiating sex and lack of educational and economic opportunities. The infection of women further propells the emerging epidemic of pediatric AIDS. This paper attempts to look at the different forms of family and marriage in Nigeria and how these relate to population dynamics. The prevalence of patriarchy and widespread practice of polygyny are seen as some of the factors reinforcing the subordinate position of women in the Nigerian family. The socio-cultural practices in these families especially those relating to sexual relations, child care and health seeking practices are explored with a view to linking their relation to the possible transmission of HIV/AIDS. The influence of migration on the STD/HIV transmission is explored in view of the high rate of mobility of peoples across and within national boundaries of African countries; voluntarily for better economic opportunites and involuntarily due to famine, civil wars and political destabilisation. The paper concludes by recommending a multisectoral approach to the issue of AIDS in Nigeria in particular, and Africa in general. Programmes designed to reduce sexual transmission will therefore have the greatest impact.

Keywords: HIV/AIDS • family • patriarchy • sexual relations • reproductive health • gender inequality.

Felicia A. Durojaiye OYEKANMI, *Relations socioculturelles dans la famille nigeriane : implications pour le sida en Afrique*

Résumé — En Afrique, les femmes sont particulièrement vulnérables au sida et les facteurs les mettant en situation de haut risque d'infection sont sociaux et économiques comme la pauvreté, la discrimination sexuelle, le manque de capacité à négocier le sexe, le manque d'opportunités dans le domaine de l'éducation et de l'économie. En outre, l'infection des femmes a fait émerger l'épidémie de sida pédiatrique. Cette étude tente de considérer les différents types d'organisation familiale et matrimoniale au Nigeria et de voir comment celles-ci interfèrent dans les dynamiques démographiques. La prévalence d'un système patriarcal et une pratique étendue de la polygynie sont perçues comme des facteurs renforçant la position subordonnée de la femme dans la famille nigeriane. Les pratiques socioculturelles dans ces familles, surtout en matière de relations sexuelles, de soins aux enfants et de pratiques pour la quête de la santé sont explorées afin de voir leur relation à une possible transmission du VIH/sida. L'influence de la migration sur la transmission des MST/sida est aussi explorée en considérant le taux élevé de mobilité des populations à l'intérieur et hors des frontières nationales des pays africains — que cette mobilité soit volontaire, traduisant la recherche de meilleures opportunités économiques, ou qu'elle soit involontaire et due à la famine, aux guerres civiles et à l'instabilité politique. En conclusion est recommandée une approche multisectorielle du sida, au Nigeria en particulier et en Afrique en général. Les programmes destinés à réduire la transmission sexuelle pourront alors avoir un impact notable.

Mots-clés : VIH/sida • famille • patriarcat • relations sexuelles • santé de la reproduction • inégalité entre sexes.