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Indigenous Etiology and Care-Seeking in HIV/AIDS among Akoko People of Southwestern Nigeria

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ABSTRACT

There is a parallel between local and bio-medical perceptions of HIV/AIDS among the Akoko people of South-Western Nigeria, as in many other societies of sub-Saharan Africa where HIV and AIDS is pandemic. Despite the fact that this accounts for resilience of the disease, earlier studies on HIV/AIDS in Africa focused on causes, prevalence, logistics and social stigma. Local meanings of HIV/AIDS and their influence on care-seeking have been largely ignored. This study examines local perceptions of HIV/AIDS among the Akoko and explains how attitudes are generated from indigenous meanings. It also examines how such attitudes inform a local etiology of HIV/AIDS. Similarly, our study examines how local meanings of, and attitudes towards the disease, set the pathway of care in its management among the Akoko people. Through qualitative and descriptive ethnography, Key Informant Interview (KII), Focus Group Discussion (FGD) and the textual analysis of documents, our study seeks to establish that HIV /AIDS are linked to both natural and supernatural causation. 83% of the respondents held that HIV/AIDS is due to witchcraft, nemesis and whoredom. These local perceptions are drawn from local conceptions which in turn encourage HIV/AIDS patients to seek assistance outside modern health care facilities. This also discourages local communities from attending health education workshops that link HIV/AIDS with germ theory and care. Treatment of HIV/AIDS is thus mostly home-based where a wide variety of traditional remedies is practiced. Our study concludes that the lack of convergence between local knowledge-contents and bio-medical explanations account for a high prevalence rate and the lack of effective management. For proper management of the disease, there is a need to understand indigenous knowledge and local concepts in order to establish a convergence between bio-medical explanations and indigenous perceptions. Only then can a community acceptable means of changing bio-medical perceptions of the disease be facilitated.

Keywords: Indigenous; Etiology; Care--seeking; Akoko, HIV/AIDS

INTRODUCTION

Every social group has a unique understanding of disease etiology and care-seeking. The Akoko's beliefs in the etiology and etymology of HIV/AIDs run contrary to the western bio-medical paradigm: a parallel assumption and perception exists that continues to deter the optimum effects of HIV/AIDs intervention and disease control among the people. This in effect partly explains as to why HIV/AIDs remain a major health problem for the Akoko people, as is the case in many other sub-Sahara African societies. Despite the national and international interventions engineered against HIV/AIDs over the years, due to the lack of convergence between local and bio-medical perceptions, the disease remains one of the causes of high morbidity and mortality rates in many sub-Sahara African societies.[1] The bio-medical optic, perceives the disease as a parasitic infection that is responsible for the deaths of thousands of people in sub-Saharan Africa, including Nigerians.

Attempts and official intervention strategies are thus generated to tackle the inception, growth and spread of the virus. Indigenous perceptions signaling the cultural specifics of HIV/AIDs and its management in sub Saharan Africa are mostly ignored. The consequence of this approach is that HIV/AIDs still remains an intractable disease that continues to affect several thousands of sub-Saharan Africans over the years. [2] HIV/AIDs accounted for the death of 6% of the mortality rate in Nigeria in 2013.[3]

HIV/AIDs infection has spread over the last 30 years and has a great impact on health, welfare, employment and criminal justice sectors; affecting all social and ethnic groups throughout the world. Recent epidemiological data indicate that HIV/AIDs remains a public health issue that persistently drains our economic sector having claimed more than 25 million lives over the last three decades.[3] The estimated overall number of People Living with HIV (PLWHIV) by the end of 2014 was approximately 36.9 million and Sub-Saharan Africa was the most affected region, having 25.8 million PLWHIV and 16% of all people with HIV infection living in the region..[4] Of all people living with HIV globally, 5% of them live in Nigeria. [5] The country already burdened by political instability and endemic political corruption which efforts to 'wipe out' the virus within a few decades unrealistic. [6] Notwithstanding the progress in institutional reforms and political commitment to tackle the disease, the country has seen more citizens placed on life saving medication of active

antiretroviral therapy (AART) to increase the survival of such HIV seropositive individuals.[6]

A further fact almost difficult to fathom, is that every hour one million people are attacked by HIV/AIDs in Nigeria who are consequently incapacitated or killed by HIV/AIDs. [7] In 2014, HIV/AIDs accounted for 10% of Nigerian disease burden,[8] and in 2016, 15% of mortality rates in Nigeria were due to HIV/AIDs. This pegged Nigeria as one of foremost ranking in HIV/AIDs incidences for sub-Saharan Africa. [9] Much attention has been given to fight HIV/AIDs globally both at national and international, governmental and non-governmental levels including several interventionist programmes.

Cumulatively a lot of human, capital and time resources have been plunged into the fight against HIV/AIDs, which remains one of dominant killers of both young and old in many parts of Nigeria. [10] While previous studies focused on economic, ecological and political aspects of HIV/AIDs management, little or no attention has been drawn to how the "local" concept of HIV/AIDs informs specific knowledge creation and how such a disease is interpreted to influence the utilization of bio-medical based HIV/AIDs interventions. The existing knowledge of HIV/AIDs lacks the "Indigenous" factors influencing HIV/AIDs resistance in Nigeria, a situation common to most sub Sahara African countries, consequently resulting in a dissymmetry between culture factors and bio-medical strategy. This situation (where the "global" eclipses the "indigenous") partly explains the poor results of HIV/AIDs intervention in sub-Saharan Africa. More specifically, the significance of local perception (which entails belief systems) matters in understanding a disease, and especially how such local understandings can come to bear influence upon the choice of healthcare sought.

As culture is an indispensable microscope for examining attitudes towards disease,[11] the cultural template of a particular morbid entity and its nosography can shed more light on therapeutic choices and the knowledge frameworks within which these choices are articulated and translated. Such specifics include local terms for disease; attitudes and responses emanating from such terms; how those attitudes construct responsibility to manage the disease and the cumulative effects such constructions on community health, arising from local understandings of the disease. Specifically, as culture contributes to differences in medical care, it also gives meanings to diseases. Culture spells out what constitutes a disease and the choice of health care

system.[12] The socio-cultural dynamics of disease also suggest that responses to diseases in terms of their management remarkably differ across human societies, simply due to cultural differences. [13] Thus there is the need to understand the cultural context of disease in any community so that a concerted response can be adequately crafted. Our study seeks to adequately engender local understandings and perceptions of HIV/AIDs in such a way that community knowledge may be considered in HIV/AIDs control mechanisms among the Akokos and by extension in sub-Saharan Africa.

Objective of the Study

1. To examines examine how local beliefs, values and customs influence local etiology of HIV/AIDs
2. To examine how local perception and etiology of HIV/AIDs influence therapeutic choice and utilization of health care resources.
3. To examine how the above implicate on biomedical aspect of healthcare.

CULTURAL PERSPECTIVES OF DISEASE EATIOLOGY

Every social group has a unique way of interpreting and handles its health challenges. This handling largely depends on the group's cosmological views, value system, beliefs, and practices as well as institutions that have developed over the years to cater for different diseases and illnesses. Furthermore, each culture has a unique understanding of illness and disease causation, peculiar medical semantics and classification, and a variety of practitioners. These attributes are however not static but dynamic; hence people's beliefs and response to disease and illness change over time. [13]

From an ethnomedical perspective, diseases and illnesses are defined within a specific social milieu, but in a situation where pluralism of care prevails the definitions could be multiple and composite. The total sum of the group's "beliefs, strategies, behaviour and interactions with environment that pertain to sickness, its management, and health status" is referred to as an ethnomedical system.[14] In other words, an ethnomedical system is constituted by the resources and responses available to a particular group in order to overcome its health challenges. Although other medical systems may be incorporated, the core concepts, beliefs, and practices of the cultural group dominate.

Aguwa argues that Africans, uphold the naturalistic and supernaturalistic views concerning disease etiology. Accordingly, diseases are dichotomised into those that require the attention of biomedicine and those that can be handled by traditional medicine. It is important to note that although many African cultural groups categorize diseases and illnesses according to cause, they regard traditional and biomedicine as complementary.[15] In addition to these two care systems, Aguwa also talks about Faith-based practices of religious therapy, referred to, in other circles, as faith healing. Thus, illnesses that frequently occur and abruptly disappear are considered to be natural. Such fleeting diseases include coughs, colds, stomachaches, and headaches. These diseases are either allowed to heal naturally or they are referred to biomedicine or traditional therapeutists, also known as herbalists. In this kind of situation, the choice of treatment is self-determined and hinges on perceived cost, acceptability, accessibility, and dependability of the medical system.

By contrast, supernatural or abnormal illnesses are persistent and life-threatening. Such illnesses usually start as normal (natural), but because they persist they are re-assessed and re-interpreted as abnormal (supernatural), thereby compelling the sick and the significant others to seek explanation.[16] The supernatural perspective is closely related to the African people's cosmological views. Many African societies believe that the supernatural beings break into the human affairs with either beneficial or detrimental effects. The implication being that, prolonged life-threatening illness is in essence perceived not as mere physical condition but as a religious matter. This dichotomisation, however, seems to be more cognitive than behavioural. Similarly, Adepetu uses the "how" and "why" theory in his explanation of health and illness in African communities. Whilst the "how" component relates to the biological factors contributing to the eatiology of an illness and the interventions deemed appropriate to eradicate the illness, the "why" component refers to the people's explanation with regard to the particularity of an illness which relates to the social and spiritual factors that are thought to be relevant to the timing of an illness.[17] Such socio-spiritual factors include the breach of taboo, effects of a curse, God or ancestral punishment for individual or communal sins, or affliction by alien spirits. Chukwu echoes similar sentiments by averring that supernatural illnesses call for explanation. For them, these illnesses are generally attributed to the neglect of ancestor spirits, angered spirits, alien

spirits, and witches and sorcerers. Because of their peculiarities, socio-spiritual illnesses are referred to diviners or diviner-therapeutists.

This categorisation of illnesses into "how" and "why" is however not this simple but complex. Apart from being a physical condition, illness is also socially defined; hence people's definition of illness varies from one stage to another. During the initial stages, illness is presumed to be normal but if it persists, the perception of abnormality creeps in. In this regard, Chukwu noted that nowadays most people make biomedicine their first choice but if the condition deteriorates they turn to traditional medicine. It is important to note that before people leave biomedicine to traditional medicine or vice-versa they would have changed their own views about the cause of the illness. Thus, views about the cause of illness are closely tied to the lag-time between the onset of illness and the expected healing period.[16]

Chukwu stresses the perceived differences in beliefs surrounding the etiology of various diseases as determining factors in the choice of therapy. Diseases classified as natural are thus commonly referred to scientific doctors or herbalists, while those considered having an essentially supernatural cause are taken to the diviner or diviner-therapeutist. However, Chukwu contends that it is not so much a question of one or the other care system, but an issue of what shall be sought and obtained from the specialist in different care systems. To this end, the same malady is often brought to the attention of the traditional healer and to the scientific medical practitioner. This syncretism is often done consciously. However, it can also operate at the sub-conscious level in that a patient may take or apply a substance believed by him/her and the specialist to ameliorate the sickness and also undertake an act, usually ritual, which may or may not directly involve the body, but which is believed to have a positive effect on health.

Friedrick observes that due to close kinship relationship in African communities, care-seeking decisions are rarely made by individuals but by the whole family and in some instances, the extended family. As such, the definition given to illness by the sick individual and his social group or significant others at any given time is the most important determinant of illness behaviour. Friedrick added that most patients and their significant others make an assessment and an evaluation of the illness primarily in terms of their own understanding of diseases, and the influence of the dominant medical beliefs of the society in which they live appear to prevail with regard to the choice of

therapy. The dichotomisation of diseases into natural and supernatural is therefore a consequence of these beliefs. [18]

Adepetu posits that for every society which uses both indigenous and biomedicine forms of therapy, there is a "hierarchy of resort," indicative of the usual sequencing in the use made of existing medical service alternatives. This means illness is first referred to a medical system deemed to be more reliable until subsequent developments prove them wrong. Informed by these theories, this paper explores, from a ethnographical perspective, how indigenous etiology of HIV/AIDS influencing the patients' care-seeking behaviour, using the case of the Akoko people of Southwestern Nigeria.

THEORETICAL FRAMEWORK

Health Belief Model (HBM) is a health behaviour change model first developed in the 1950s by Social Psychologists, Houchbaum G.H., Rosenstock I.M, and Kegel. According to Gtanz, Rimer and Lewis, the proponents used the theory in its original form to explain why free medical screening for tuberculosis offered by the U.S. Public Health Service was not successful. However, the model has been furthered by Howard Becker and colleagues in the 1970s and 1980s. Subsequent amendments to the model were made as late as 1988, to accommodate evolving evidence generated within the health community about the role that knowledge and perceptions play in personal responsibility.

In its latest packaging, the HBM has been defined as a conceptual tool used to understand, explain and predict health behaviour (curative and preventive), including possible reasons for non-compliance with recommended health action. In its task of explaining and predicting behavioural responses to treatment and other health services (health behaviours) and to promote uptake of health services, HBM focuses on the role that knowledge, belief, perceptions and attitude play in personal responsibility, decisions and actions toward a disease or health service.

Conner and Norman identified three broad areas of application of HBM. These are

a. Preventive health behaviours which include health promoting (e.g. Diet, exercising) and health risk behaviours (e.g. Smoking) as well as vaccination and contraceptive practices.

b. Sick role behaviours which refer to compliance with recommended medical regimens usually following professional diagnosis.
c. Clinic use which includes physician's visits for a number of reasons.
The core assumptions, propositions and statements of HBM are based on the understanding that a persons' willingness to take a health action or change his health behaviour in a recommended direction is hinged on four major considerations or constructs. These are:
a. Perceived susceptibility (an individual's assessment of their risk of getting a condition.
b. Perceived severity (an individual's assessment of the seriousness of the condition, and its potential consequences)
c. Perceived barriers (an individual's assessment of the influences that facilitate or discourage adoption of the promoted behaviour)
d. Perceived benefits (an individual's assessment of the positive consequences of adopting the behaviour). A variant of the fourth construct include the perceived cost of adhering to prescribed intervention.
Two constructs added later were:
e. Perceived Efficacy (an individual's self assessment of ability to successfully adopt the desired behaviour).
f. Cues to action (external influences promoting the desired behaviour).

The four major constructs of perception however respond to modifying or mediating factors that affect behaviour. Such modifying factors include the media, health professionals, personal relationships, incentive, culture, education level, past experiences and skill etc.

Against the above background, HBM has become a very useful tool to explain the problems associated with HIV/AIDS and its control programme in society. The quantum and nature of knowledge, beliefs, perception and attitude toward HIV/AIDS is largely negative in many societies. This affects actions and decisions of individuals toward the disease. Despite strong perceptions of susceptibility and severity of HIV/AIDS, HBM explains poor compliance to treatment and low uptake of HIV/AIDS services as products of barriers posed by socio-cultural interpretations that stimulate a preference to cover-up the disease among victims. Among health workers, the perceived risk of contracting HIV/AIDS surpasses their estimation of perceived benefits from participation in HIV/AIDS management process. This accounts for their poor

attitude to HIV/AIDS control duties. Unfortunately the role of mediating or modifying factors like the media and incentives has been abysmally low. They could not attenuate the negative perceptions of victims, health workers and the public hence the tenacity of HIV/AIDS and its related problems in society.

Study Area

Akoko is situated in North Eastern part of Ondo State, Nigeria. Located in an upland elevation with a hilly settlement, it shares its northern and eastern boundaries with Kogi and Edo states respectively and western boundaries with Ekiti state. Akoko is the largest community in Ondo state with 17km wide and 35km long. Akoko lies on the latitudinal range of between $7^{0}46^{0}$n and $7^{0}52^{0}$n and on the longitudinal range between $3^{0}85^{0}$e and $3^{0}89^{0}$e to the north of Kogi. Akoko community is made up of a collection of small towns. The population is estimated to be approximately 509,113 but that number is continually being adjusted due to the high levels of in and out migration for work abroad. Two-thirds of the populations live in rural areas of Akoko community. The largest town is Ikare-Akoko. Akoko takes a large percentage of the local governments in Ondo state. Out of the present 18 Local Government Councils it takes four Local Government Areas (LGAs), viz Akoko North-west, Akoko North-East, Akoko South-West, Akoko South-East. Akoko comprises about 40 small towns, predominantly situated in rocky areas of Ondo state. The rocky terrain nevertheless, may have helped the region to become a melting pot of sorts with different cultures coming from the north, eastern and southern Yoruba towns and beyond. Akoko became one of the few Yoruba clans with no distinctive local dialect of their own.

METHODS AND MATERIALS

HIV/AIDs in Akoko is a telling, important example, where the resilience of HIV/AIDs in Akoko can be scrutinized in terms of the lacking reconciliation between the bio-medical and local perceptions of the disease. Certain research questions drive the present enquiry: In what ways has the local term(s) for HIV/AIDs influenced the local perception of HIV/AIDs? How is the bio-medical perception of HIV/AIDs related with the Akoko local perception of the disease? In what ways does the local perception of HIV/AIDs determine the choice of therapy in HIV/AIDs management among the people? Is there any relationship between the local perception of HIV/AIDs and the level of prevalence of the

disease among the Akoko? What is the pattern of utilization of medical facilities in HIV/AIDs management among the HIV/AIDs? Specifically, our study focuses on local cultural specifics such as the perception of disease arising from local terminologies, beliefs and attitudes and how such cultural contents knowledge-creation influence HIV/AIDs management among the Akokos of Ondo state state, Nigeria. In this study, the local knowledge of and attitudes towards HIV/AIDs were investigated alongside the beliefs that define, enforce and enhance such local perceptions. Through descriptive ethnography, the western ideas of HIV/AIDs to solving the disease were equally investigated.

Within this baseline, local ideas were critically analysed to see if there a point of reconciliation between the two existed. Further, to explain how such worldview impacts on etiology and management of HIV/AIDs, our research engaged in multi-lateral, comprehensive and descriptive ethnography. Drawing largely from the *emic* approach (how people think), albeit with some sense of *etic* perception (what is ethnographically important) of Akoko in the world of HIV/AIDs, our study is data driven and community centred.

Our investigation is also case specific as no two cultures are almost the same especially in the construction of cultural ideas through symbolic representation. Our study was designed as a descriptive ethnography, relying exclusively on qualitative methodology where both the individual and the community served as the basis of data interpretation. The need for this arose from the desire to capture a multi-lateral perception of local culture surrounding the etiology and management of HIV/AIDs in the Akoko region. In addition an inter-subjective non-systematic selection of the respondents was employed, since HIV/AIDs infection is non-spatial in restriction.

It is also highly unlikely that an Akoko resident has not experienced the infection. Hence, to grasp as many local perceptions as possible, an extensive ethnographic study of the Akoko people and its responses to the disease was carried out in a culturally sensitive context. The local language, Akoko, was used in the field with research being conducted using both emic/etic frameworks. Indigenous knowledge and beliefs associated with the disease were interrogated using folk or local terminologies based on the cultural context of the disease.

Traditionally, heathcare system among the Akoko was carried out in the context of the traditional / indigenous religion. This involved the use of both natural and supernatural means to maintain good health prevention and cure

diseases. Medicine and magic were practiced hand in hand, commonly so, by traditional healers in the quest for health sustainability among the people. Plants and other natural substances were heavily relied upon for the prevention of physical ailments while magico-religious rituals were used for those suspected to have supernatural undertones.[16] Even today, the Akoko people are known for their belief in the efficacy of herbal remedies and ritual practices in the prevention and cure of certain diseases. The notion of germ theory in the etiology of disease is completely alien to Akoko culture.

It is believed by the Akoko that diseases are caused by a person's lifestyle/habits of consumption and supernatural factors. In Akoko cosmology, animals, insects and other natural elements do not cause or transmit diseases except when they are used by the gods as a punishment against a person, or group. Our study population involved three sets of residents:
Adults aged 18 years above; Health and Medical practitioners both traditional and modern; and People living with HIV/AIDS who are able to narrate previous and current experiences of the ailments.

Secondary data were sourced from textbooks; academic journals; magazines and government /organizational publications. Primary data were collected from the field relying on the triangulation of key informant interviews, Focus Group discussion (FGD) and Non-participatory Observation.

The study relied on non-systematic sampling. Hence a sizeable number of respondents were selected to achieve objective and generalized data from the field. Specifically, each of the non-systematically selected respondents was engaged in deep and intensive interview. The sampling produced the selection of: 8 research communities both rural and urban on equal divides from 4 government areas.

A total of 21 key informants were used across the 8 study locations: and an average of 2 key informants was used in each research location. Some of the informants were identified during the pre-field visit and others during the FGD sessions were singled out for further interview. These respondents provided testimony on traditional treatment regimes and processes involved in the preparation and administration of traditional remedies in HIV/AIDs management. Traditional and modern healers, caregivers, as well as HIV/AIDs patients were selected and interviewed on a one-on-one basis. The instrument used for the key informant interview consisted of 12 open-ended question

guides that allowed the respondents to freely express opinion on the respective issues under investigation.

Eight sessions of Focus Group Discussion (FGD) which consisted of average of six people were held in all field locations, which served as avenues for self expression. Information so gathered was used to complement the data obtained through other methods. Each session was limited to six discussants and lasted one hour. This was to ensure sufficient time for each participant to air his/her views. Interview sessions were interactive in order to elicit comments and responses that clearly brought out local terminologies associated with HIV/AIDs and the cultural significance of the disease.

8 sessions of HIV/AIDs care were observed mainly through non-participatory observations. Included in the observations were the traditional and modern healers, caregivers as well as HIV/AIDs patients, who were selected across all the study locations. It was also observed how patients responded to HIV/AIDs in order to gather first hand information on therapeutic choices and the perceptions of HIV/AIDs care. Specifically, informants communicated key research issues such as indigenous knowledge and the community conceptualization of the disease, beliefs associated with it, ways of diagnosing HIV/AIDs, responses to its symptoms, care given to HIV/AIDs patients and the pattern of utilization of both traditional and Western medical facilities.

The sessions were moderated by the researcher and research assistant. A tape recorder was used to record the sessions. This was done in order to capture all the information offered through the sessions that may be missed by manual recording. The instrument consisted of open ended questions raised from the research questions.

Our study furnished both quantitative and qualitative data. The quantitative data from questionnaires were analyzed using descriptive analysis. Content analysis was involved as data analysis for the qualitative data. This process entailed deep routine interaction with data generated from the field on a daily basis throughout research sampling phases. Immediately after fieldwork sessions, all generated data were crosschecked and, where needed, further visits to sites were undertaken to fill certain gaps in the "raw" data collection. Following editing, transcription from electronic devices and translation of data into the English language was undertaken. Both the data from the research field diary and notes were extrapolated with that retrieved from the electronic

devices. Sorting of the data according to the research objectives involved the writing of study objectives on separate sheets of paper, which were referred to as "objective cards" (this enables the researcher to constantly check the cohesion of his findings in line with the aims and outputs of research – one could call this a "running point" of reference). Interviews were filtered to allocate relevant data to the appropriate "objective cards" which formed the frame and general rationale for report writing. All data was thoroughly anonymized to protect the identity of participants.

RESULTS

The Indigenous Etiologies of HIV/AIDS in Akoko

The Akoko, like the generality of African ethnic groups, maintain a very close link between health and traditional cosmological beliefs. Among the Akokos, "reality and mythology are inseparable in everyday life". They presuppose each other and require one another because together they complement each other in creating a greater reality. By and large, responses from 87% of FGDs participants showed that both traditional and modern perceptions of health and disease are prevalent in present day Akoko community. In vernacular a respondent said, "*Awon aisan kan wa to je oju lassan, awon kan si wa ti kin se oju lasan"*, meaning 'there are some illnesses that are ordinary, while some are not ordinary'. This revealed that Akoko people dichotomise illness into two- that is, "normal" (natural) and "abnormal" (supernatural), and this categorisation pre-dates HIV/AIDS. The Akoko conception of HIV/AIDS-related conditions is not simple and straightforward. Their classification of HIV/AIDS into either "normal" or "abnormal" illness depends on factors such as the individual, family, and community's perception and definition of the visible symptoms, life history of the sick person, family history, and religious affiliation. The complex and multifaceted ways through which HIV/AIDS manifests aggravates the whole situation.

Responses from participants indicate that the people hold the belief that, the disease defers medical solution. In all the study sites, 67(93%) respondents categorise the ailment as abnormal because it is seen as persistent and life-threatening disease. Among the Akoko, the disease is mostly referred to as *aisan-kogbogun* meaning "incurable ailment".

Both Key informant and FGDs participants demonstrated a general understanding of common HIV/AIDS symptoms. Based on their responses, it

was revealed that HIV /AIDS manifests in a variety of ways, which include loss of weight, skin rash, swollen lymph nodes, diarrhoea, tuberculosis, change in skin and hair texture. In all the study sites, 23% of the respondents hold strong to the fact that the disease is caused by virus. Information gathered revealed that this category of Akoko people consider HIV/AIDS to be "normal". The illnesses are first interpreted as "normal" and later on as "abnormal" if they recur in a severe manner. In this sense HIV/AIDS are generally thought to be a moral illness, in that the infected person is regarded as of loose moral. In vernacular they say, *"Oniranu"* or *"Onisekuse"* meaning he or she is a whoredom.

However, in cases where HIV/AIDS symptoms are not interpreted as HIV/AIDS symptoms, the sick, together with his or her significant others, seek for a causal explanation from the scientific and or spiritual realms. In this situation, HIV/AIDS cease to be a typically moral challenge. Concerning the life history of the sick person, if the sick individual were known to be of loose morals, the Akoko quickly explain any depreciation in health morally, with minimum consideration of the symptoms. A participant shed more light as he said, "if a flirt person manifests any of the symptoms people will see it as normal and ordinary, if the sick person's sexual forays were unknown, then ill-health is likely to be explained in terms of other causes". In all the study sites, 77% of the respondents claimed that the disesase is beyond bio-medical explanation. The causation was linked or attributed to supernatural forces such as ancestor, alien, or avenging spirits, especially if the victim has a devilish and or questionable character. A respondent clarified, "some people are very dubious and wicked, and their relationships with others are shaky thereby prompting the ancestral spirit to afflict them with HIV/AIDS-related illness". At times, as explained by the respondents, the symptoms are not very obvious to the community members.

Family history also influences people's explanation of ill-health. If an individual is from a family known to be haunted by avenging spirits and suffers ill-health without showing visible or community-defined HIV/AIDS telling symptoms, then the HIV/AIDS-related illness is attributed to the spirits. In all the study sites, 9 (12%) respondents opine that HIV/AIDS were invented and imported into African societies by Europeans in an endeavour to wipe out the black race. Yet, 63(86%), respondents claimed that it is a divine punishment against the moral rote of the society. The dual interpretation of HIV/AIDS,

depending on the peoples' understanding of the visible symptoms, as "normal" and "abnormal," does not only indicate people's dilemma but also defines the care-seeking and selecting behaviour of the sick person and his or her social group.

The study also established that religious affiliation plays an important role in determining how HIV/AIDS symptoms are viewed and interpreted. In focus group discussion, 4(6%) participants who practice both African Traditional Religion (ATR) and Christianity explained the death of their relatives in terms of the HIV virus. The other 10 (14%), participants attributed the death of their relatives to witchcraft, although other observers alluded to the fact that the late relatives had died from HIV/AIDS-related conditions. A respondent has this to say, "witches are taking advantage of the virus, take innocent people's life, and use HIV/AIDS as a scapegoat. All the participants agreed that people can also contract the virus if ancestors are not happy. Ancestors register their disgruntlement by allowing misfortunes such as HIV/AIDS virus to attack the living.

Indigenous Etiology and Care-seeking in HIV/AIDS in Akoko

Diseases and illnesses thought to be related or unrelated to HIV/AIDS are therefore defined by the community. Apart from bio-medical hospitals, there exists no technology among the Akoko cultural group that is used to verify whether or not a person is infected with the HIV/AIDS virus. Thus, most HIV/AIDS patients among the Akoko, together with their significant others, make an evaluation of their illness primarily in terms of their own understanding of diseases. While the interpretation of words may give rise to action and feeling, local diagnoses of HIV/AIDS arise from inferences drawn from local names given to HIV/AIDS in the Akoko regions. Diagnosis is mostly based on the symptomatic or physical symptoms such as weight loss, tuberculosis, headache; loss of appetite, and paleness among others. A respondent clarified, "whenever anyone is sick or complains of discomfort, or losing weight rapidly, the first question he will be asked is 'have you gone for test?" As noted in the field during the observation of HIV/AIDS episodes, there is a common knowledge of how the individual feels health wise. Ill-health due to HIV/AIDS is often measured by the chronic cough and extreme weight loss. Another respondent also clarified, "the victim will be getting lean and lean everyday without identifying the particular cause persee" Unfortunately,

HIV/AIDS symptoms begin to show when the illness is already in its advanced stage. Various scenarios, indicative of the dilemma the Akoko people face in handling HIV/AIDS, were discovered.

The early symptoms of HIV/AIDS infection fit well into the Akoko people's natural or normal category of disease and illness. When symptoms is perceived as mild and normal, the early symptoms are taken casually and are often referred to the nearby clinic or local therapeutist. Under this circumstance, biomedicine is usually the first choice. However, as the condition deteriorates and HIV/AIDS' characteristic symptoms begin to manifest dangerously, according to the judgment of the community, therapy preferences also change. Defining symptoms, together with the agenda, announced or concealed, of the nucleus and sometimes extended family, also determine the "course of action" or treatment response. If the sick individual and the family are operating within the "announced" agenda, the subject matter of the illness is disclosed and the social group may advise accordingly with regard to healthcare choice. A respondent comment, "at times it is one close relative and or associates that will draw your attention to susceptibility of the virus when you are ignorant"

Community folk tend to rely more on local remedies against HIV/AIDS' especial when it is perceived as abnormal. This is informed by their holistic conception of health and illness, based on their cultural milieu. According to respondents, this usually includes care-seeking practices such as praying, fasting, exorcism, appeasement ritual, etc. One of the respondents shared, "there is no way you can cure the virus ordinarily because it is stubborn, and you have to adopt supernatural means for cure".

The use of biomedicine for care is not totally ruled out, traditional/home remedies remains a priority. People see orthodox medicine as culturally alien and abstract since the processes of producing such medicines are not regionally known, unlike traditional treatments. 51 (71%) respondents believed that local remedies are more effective against HIV/AID, while 12 (17%) respondents argued that orthodox medicine is more effective and 7 (10%) believed that for HIV/AID to be effectively cured, the traditional and western medicines must be combined. Most of those in the last group believe that local remedies must be taken first. As emphasized by a respondent, in HIV/AID control, "you engage appeasement ritual and fasting/prayer to cleanse the residue of Virus before you take the biomedical drugs." At the onset of symptoms, the infected person(s) resume(s) disease culture, which includes a number of inabilities such

as eating, sleeping, walking, playing, and other incapability suspending normal active practices and behaviours. As these inabilities create fear of economic loss, dissociation from the community functions, bewitch and possibility of death, both the infected and the relation engages in sick role including sourcing for care and supporting the patients in his/her sick behaviours. The conditions open up a pathway of care.

Data obtained through interviews and observations show that the dilemma of the HIV/ AIDS patients aptly manifests in the three levels of interaction of these care systems. These interactions usually take place after the sick person and his/her social group has changed their definition of illness. The change of definition is due to the general classification of disease and illness into "normal" (natural) and "abnormal" (supernatural) and points to a degree of uncertainty as to whether the illness is normal or abnormal. A participant clarified, "When it is perceived that the symptom is mild and normal we use to engage both home remedies and biomedicine. When perceived as abnormal we engage purely in home remedies." This according to respondents is that using bio-medicine drug for illness that is spiritually wired is waste of effort and resources.

The stages in the pathway of HIV/AIDS care in Akoko land are not always followed serially neither are they mutually exclusive. Though, according to respondents, priority is mostly given to home remedies; there are cases when a patient is being treated simultaneously with traditional remedies and orthodox drugs. As a patient in charity hospital shared "I was initially adopting traditional remedies, when there is no improvement my people took me to this charity hospital" Information gathered revealed that some victims at times engage biomedical first, and later opt for tradition care when there is no improvement.

It is not uncommon for a person to take or engage in ritual appeasement/ cleansing and visit the hospital for treatment. Responses from participants show that the rural Akoko people refer HIV/AIDS suspected cases to traditional medical practitioners and faith healers to get rid of supernatural forces that may worsen the condition and to biomedical practitioners to relieve pain and symptoms. There are cases where consultation with both faith-based healers and traditional healers are done hand in hand. While some people go through these stages one after the other, some can engage two or more of the stages at the same time. Others still can skip any of the stages or even revert to a

particular stage that had been earlier engaged during the same illness episode. This leads to fatalities in some instances. The syncretic behaviour also shows desperation on the part of the sick person and his/her social group. Syncretism, involving the creative combination of elements of traditional and western medicines based on the demands of each given situation is the dominant pattern of care-seeking among the people. A patient starts using either of the three systems and then move on to the other systems. There is oscillation among the care systems as the illness intensifies. This behaviour is necessitated by the realization that treatments from a particular care system are not bringing the desired results. The illness is reassessed and redefined, thereby compelling a change of direction towards another care system. This explains various charms from traditional medical practitioners and faith healers that are often tied around the wrist, ankles, neck, or waist of the sick person or placed in the house to ward off evil spirits and witches who may want to take advantage of the compromised immune system.

Complementarity is by far the most common relationship and exists in situations where people consider resources from the healthcare systems as necessarily vital for complete healing to take place. It manifests when the chronic illness is thought to involve natural, psychological, and spiritual factors. Illness behaviour is cyclic because the individual moves or is moved from the clinic/hospital to a religious shrine for rituals. Herbs, charms, and holy water are even administered to clinic/hospital admitted patients. In this mode, there is a constant flow of patients among specialists of the prevailing healthcare systems. The aforementioned behaviours show that the Akoko people, like various other cultural groups who share pluralistic care configurations, learn to use and rely on different aspects of the prevailing systems of care (the concept of mutual accommodation). The rural Akoko people's pathway to care varies according to definition given to illness, presumed acceptability, accessibility, and dependability of a particular care system. Stigma, agenda, desperation and religious orientation also influences care-seeking and selecting behaviour in no small measure.

DISCUSSION AND CONCLUSION

Akoko people hold the belief that HIV/AIDs is caused by a plethora of different factors ranging from whoredom, spiritual attacks and host of others. The local perceptions of HIV/AIDs as an incurable disease generate a fear on

the mind of victims and Akoko people in general. Based on this belief, interviews and observation indicate that the traditional ways in which HIV/AIDs is managed are parallel to western/bio-medical ideas. The people repose much confidence in the efficacy of traditional remedies.

In instances of HIV/AIDs people initial adopt local remedies; but at times they do not hesitate to try out different remedies until, they stumble on the one that really works for them. This therefore promotes pluralistic care which is more prevalent in illness management in Nigeria. Hospital visits for HIV/AIDs is quite low in Akoko, especially in the rural areas due to their customary values. Most of those who go to the hospital for HIV/AIDs care do so at an advanced stage of the disease when the disease might have set in complications. This occurs regularly as local remedies might have failed to give the patient relief from the illness. Others it was discovered do so just because they are expected but not out of conviction. They therefore go to the hospital only after having undergone traditional treatment regimes.

Continued reliance on traditional remedies for the treatment of HIV/AIDs makes a strong case for the integration of traditional remedies into HIV/AIDs care. It calls for attention by government and other stakeholders to look in the direction of supporting researches into the various traditional remedies used in the management of HIV/AIDs. This would go a long way to ascertain the efficacy or otherwise of these remedies. It would also help to control the use of these remedies in order to stamp out hazardous practices among the people. The health of the people would be the better for it.

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