Gender Inequality and HIV Vulnerability in Plateau State, Nigeria

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Received Date: August 07, 2017, Accepted Date: October 16, 2017, Published Date: October 26, 2017.

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Abstract
This article is part of a larger study, which sought to investigate the nature of gender inequalities in vulnerability to HIV/AIDS in the Plateau State, Nigeria. Data were obtained mostly through focus group discussions and in-depth interviews with community members including opinion leaders. It was found that gender inequalities are pervasive in all aspects of social life due to prevailing patriarchal power relations; the gender situation makes women more vulnerable. HIV vulnerabilities are also exacerbated by poverty-driven behavior and choices. The female population was found to be more vulnerable especially the youth who are pushed by material privations into transactional sex – sometimes without protection. There is also a general increase in alcohol consumption and some substance use by male and female youths, with the attendant diminished sense of responsibility, which predisposes them to engage in risky sex. The seeming reluctance of the Nigerian State to locate the HIV/AIDS epidemic and intervention in the broader structural context within which it occurs enables programme implementation to ignore the structural issues of gender, power and poverty which drive vulnerability.

Keywords: Gender inequality; Patriarchy; Vulnerability; HIV; AIDS; Transactional sex; Risky sex; Poverty

Introduction
The pattern of HIV infection in sub-Saharan Africa has been observed to be different from most other countries. This is due to the fact that heterosexual relations remain the major mode of transmission leading to the feminization of the epidemic in the region [1]. Marriage has been described as a major risk factor for women, while young girls involved in transactional and or cross-generational sexual relationships also impose greater risk. This is because like in most transactions, the buyer dictates the terms, including condom use, or its lack. Gender inequalities have been identified as fueling the epidemic and Nigeria is one of ten countries with gender inequalities contributing to the infection, thus requiring an intervention to mitigate the prevalence [2,3].

Plateau State, North Central Nigeria has been a recognized location of high HIV prevalence, its 2014 prevalence was 5.8%. The state is ethnically diverse with a count of over 50 ethnic groups [4]. Plateau is a bustling center for business and tourism and draws visitors from all over Nigeria and neighboring countries. It is nicknamed the home “for peace and tourism” where many recreational activities provide free mixing of all kinds of people, including commercial sex workers. The State’s prevalence was the highest of the three States that had data derived from the first national HIV-Syphilis seroprevalence sentinel survey (HSS) among women antenatal clinics attendees during the 1991/92, 1993/94 and 1995/96 with prevalence rates of 6.2%, 8.2% and 11% respectively [4]. The State Action Committee on AIDS (SACA) responsible for coordinating the response at this level was one of the first to transform from a committee to an agency; this has ensured consistent budgetary allocations from the government. However, the State’s prevalence rate has remained higher than the national average, the Plateau average rates of the last two HSS conducted in 2010 and 2014 was 7.7% and 6.0%; compared to 4.1% and 3.0% national rates [5]. Like most other states, Plateau State has a generalized epidemic. This informed the need to investigate whether and how gender inequalities may account for vulnerability to HIV and AIDS in the state.

Literature on Gender and HIV/AIDS
The prevailing gender relations in every society affect and reinforce sexuality issues and these affect the prevalence of STIs including HIV/AIDS, with different impacts on men and women. Other dynamics include definitions of what is appropriate sexual behavior for men and women, and how these heighten the vulnerabilities of both to sexually transmitted infections (STIs). There are also issues of definitions of masculinity which encourage men to be expressive and initiate relationships (including non-commercial, marital and non-marital) while women are expected to be passive recipients of these advances, which can constitute a risk for both genders in the transmission of infections [6–8].

By tradition in most of sub-Saharan Africa, polygyny is widely practiced. The number of wives is recognised part of the index of a man’s wealth and social standing in society; they also provide farm labour. In some cases, such as South West of Nigeria, older wives even take the initiative to find younger wives for husbands to get relief from farm labour [9]. According to Orubuloye et al. [10] in the same region, significant number of both men and women in rural and urban areas, whether in monogamous or polygamous marriages, believe that men had ‘natural’ sexual urges, which predispose them to more than one partner. In the face of HIV, these gender norms and power relations that guide sexual behaviour also constrain women in being able to demand for safe sex, since the decision on sexual matters rests almost exclusively with men. Studies have shown that the incidences of intimate partner violence (IPV) are sometimes triggered by a woman’s demand for safe sex [11,12]. Thus, the power relations in sexuality matters vest advantages on the men which at the same time constitute a grievous risk of transmission of STIs and HIV to both genders.

Other studies [13] indicate that the sexual unions of older men with younger women drive HIV transmission as the latter are at risk from the men who have had longer periods of sexual exposure. A study of young girls and men in Kenya in cross-generational relations reveal that some of the men preferred the younger girls because they are polite and not likely to challenge them. The younger girls help older male partners to relieve stresses of marital life, and such relationships were viewed as a source of a status symbol among peers and also a source of a psychological boost in recapturing youthfulness. The young girls did not perceive the risk of infections from STIs and HIV which could result from such relationships. Their focus was, instead, from the fear of violence from their lovers’ wives; disapproval from parents or violence from boyfriends who of the same ages. Some of their low-risk perceptions was based on the erroneous assumption that they and their lovers’ spouses were his only sex partners [14].
Poverty is a driving force pushing many women and girls both in affecionate and transactional (i.e., women who exchange sex for gifts or favors both in cash and kind, though not involved in full-time commercial sex work) relations as well those in sex work powerless in decisions concerning about their sexuality. A study of condom use among CSWs in South Africa [15] reported that while the CSWs knew about HIV risks, they accept higher rates for unprotected sex. One of the sex workers explained: ‘I’d rather die of AIDS in 10 years than die of hunger next week’ [15]. Similarly, women have been shown to be economically dependent on men whether in marital or non-marital relationships and are therefore in a weak position to demand safe sex. The study of young girls in cross-generational relationships in Kenya similarly showed that some of the couples begin by using condoms but over time, the practice is stopped and some of the young girls who wanted to continue using condoms faced threats of the termination of such relationships and its privileges [14]. The older men’s preference for younger girls is informed by the fear of infection from older women, but sometimes, the older men who are HIV infected go for these girls in a belief that their infection can be cured sex by ‘younger blood’. They also seek out virgins (who are mostly poor and need their monetary and material gifts). These practices have led to even the sexual molestation of children in Southern Africa; child molestation was similarly reported in Kano, Nigeria. It is however uncertain whether the motive was to cure AIDS [16].

The skewed gender relations against women contribute to the feminization of HIV/AIDS because of the main mode of transmission through heterosexual sex; in numbers infected, women have higher figures. At the turn of the century, there were twelve to thirteen infected women to ten men [13, 17,20]. Marriage has been identified as the risk factor for many women who generally have one-lifetime partner; over 90% of married women were infected by husbands [21]. Among young women aged 13-19 who are infected, twice the numbers are likely to be married [17]. The practice of post-partum abstinence also contributed to women’s vulnerability as men resorted to extramarital affairs during this period [10,22]. Despite the risky behavior of men that increases women’s vulnerability, Alubo O et al. [23] found that women infected with HIV are the ones punished—they may be divorced.

The literature has shown how gender interacts with other factors to produce a gendered landscape but addressing gender at the interpersonal levels has remained a challenge due to beliefs and practices in relationships that put everyone at risk. This essay examines the perceptions of HIV prevalence and how the factors mentioned above interact with gender to increase vulnerability.

**Theoretical Review**

From the Liberal Feminism perspective, which is here adopted, inequality exists between the genders, which influences the identities and normative roles the genders assume in social life. Such social constructs relegate women to roles in the domestic sphere, which though critical, are undervalued, unremunerated and considered less important to the tasks performed by men. When women engage in productive roles in the public sphere, they experience both vertical and horizontal segregation in sex-typical occupations, which resemble their domestic roles and are found in more subordinate positions, which have lower income. These inequalities reduce the capacity of women to achieve their full potentials and relegate them into low social and economic statuses, increasing their dependence on men. This reduces the power for independent decision making that is inimical to both the individual and society, particularly women who bear the brunt of such inequalities in private and public life [24–26]. This perspective has brought the most gains to gender discourse through international agreements and conventions that recognize and support the equal treatment of women in society. The lobbying and appeal to authorities at international, national and local as well as an appeal to a reasonable public, has brought about gains and changes albeit differently in most societies. This position on gender inequality is employed in this study against other perspectives. While Sodo-biologists have not demonstrated adequately that biological difference affects productive capacities and therefore the different valuations of men and women in society, the claims of Structural Feminism that the end of a capitalist mode of production, which they posit underpins the unequal relationships in society is inappropriate for this study [24]. First, the urgent need to mitigate the HIV pandemic cannot be deferred till the contradictions of capitalism lead to a revolution, neither has there been proof from the human rights abuses experienced in the defunct USSR and Cuba that the Socialist system offers an equal platform to all its citizens, which women can benefit from. Radical feminism basically locates the problems women face to men and the reproductive roles that keep them dependent on the abusive relationship. Extreme perspectives recommend a breakaway from such domineering relationship as well as reproductive technologies that would free women from such functions [25,27]. Most of the relationships of women are desirable and require being more egalitarian. Thus information on the nature of such inequalities and the dissemination of such for advocacy and community engagement advance the cause of human rights much more, particularly with HIV pandemic, which has been recognised globally as a security threat to human existence.

**Methodology and Data Sources**

The population studied were people aged 15 years and above living in Plateau State. It is recognized that adolescents, particularly girls become sexually active from an early age, at age of 12, many are already married off. A recent study used the results of a State-wide prevalence study by Plateau AIDS Control Agency that categorized the local government areas (LGAs) into areas of high, medium and low prevalence [28] to purposively select an LGA from each stratum, reflecting the social and geographical character of the state. In addition, Jos North, which together with Jos South has parts of the administrative structures of the State and is the commercial hub of the city, was included due to its cosmopolitan nature.

1. Jos North Local Government (high prevalence of 16.07%) has a total population of 437,217 (220,856 males and 216,361 females). The urban location of Apata is heterogeneous area and made up of different ethnic groups, with high, medium and low-income earners in both public and private sectors of the economy. It is largely a Christian dominated area. The rural-Kungla is a more homogeneous society comprising of the Anaguta but also the presence of other ethnic groups and a few students of the University of Jos staying off-campus. Most people are peasant farmers and low income, there is a significant number of Fulani in one part of the area but they declined participation in the FGDs.

2. Shendam LGA (high prevalence of 12.20%) has a total
The qualitative methodology comprised focus group discussions and semi-structured interviews (SSIs), which were conducted with community members and key informants respectively. A total of eight focus group discussions were conducted in each local government area with female and male youths as well as with female and male adult in the urban and rural areas, giving a total of 32 FGDs and 29 SSIs with community opinion leaders and health service providers. The quantitative data were analyzed using the statistical package for social sciences (SPSS) software to generate descriptive statistics (frequency distributions, percentages) on some aspects of the FGDs. Qualitative methods were used in the analyses of FGDs, SSIs.

### Background Characteristics of Respondents

A total of 339 people made up of 207 (61.1%) female and 132 (38.9%) male participated in the focus group discussions. There was an almost equal representation of youth and adults who participated in the study 160 (47.2%) male and female youth (15–30 years) and 179 (52.8%) male and female adults (31 years and above) though about 27 participants could not provide their ages. A total of 2,655 participants provided information on their educational attainments, which showed that most respondents (61.6%) had attained primary and secondary education. Less than a third has tertiary education. These levels of education limit the capacity of those just entering the job market especially to be employed in the formal sector, where higher certification is required for the middle and top positions. Most respondents are employed in the private sector with many self-employed as farmers, traders, or engaged in artisanal trade. Less than 20% of the participants are in the formal public/private sector. A significant number of the respondents (35.9%) have no source of income either because they are students or are unemployed; many in this category engage in casual labor. About two-thirds of the respondents are married or have ever been married, while a third are single. Up to 76 (27.6%) of respondents have no children but among the rest who have, less than 20% of them have as many as seven or more children.

### Findings

#### Perception of the Existence of HIV and Prevalence In Communities

Respondents from all the groups affirm the existence of HIV in their communities. This acknowledgment is indicative of the generalized nature of the epidemic, which is no longer denied. Moreover, various means of interventions have increased awareness of the epidemic in most parts of the state. Opinions from all groups were that HIV prevalence was increasing in their communities.

Moral decadence in the society was blamed for the increase due to greater casual sex especially among the youth; this was also blamed for more teenage pregnancies. An adult male explained ‘At night you find male and female youth hanging out. You don’t just get HIV unless through sex’ (FGD, Adult Males, Apata). A male youth similarly asserts that ‘The infection is on the increase because the rate of sexual immorality is also on the increase; teenage pregnancy is also on the increase’ (FGD, Male Youth, Shendam). More alcohol and substance use with the attendant diminished responsibility is reported among male and female youths.

Some of the people living with HIV and AIDS (PLWHA) said that there is an increase in HIV infections due to personal vendetta to infect others. This view is expressed in all the sites as illustrated in these statements: ‘People knowing they are infected deliberately transfer it to others’ (FGD, Male Youth, Shendam). This position is re-echoed by a female respondent in Kuru: ‘Men and women sleep around, sharing it around, and saying “I don’t care, I don’t want to die alone, so I’ll share it”’ (FGD, Female Adults, Kuru). The youth are also blamed for the attitude of deliberately infecting people through unprotected sex.

The use of Anti-Retroviral Therapies (ART) was identified in most communities as increasing HIV prevalence. The respondents allege that with ARTs, PLWHA live better and healthier lives, which reduces the fear of HIV as a condition of certain death and debilitating outcomes for those infected, therefore some of the initial fears have disappeared leading to risky sex. A participant sums up this position: It is increasing because people infected look healthy due to drugs, so everyone should have his wife because some men meet small girls and pay them for sex which increases the infection. “I don’t want to die alone, so I’ll share it” (FGD, Female Adults, Kuru). The youth are also blamed for the attitude of deliberately infecting people through unprotected sex.

Information about whether the HIV is falling is not definite. There is some consensus that there is some decline in the urban areas, mostly due to awareness campaigns. The situation in the rural areas is said to be the reverse. Access to information was said to be limited to the majority who live there and thus an indication that prevention messages are not getting through.

Majority of the service providers interviewed indicate that HIV prevalence has decreased in the communities because of increased awareness. Fewer positive cases are found in routine tests due to increased condom use and the availability of ART. However, a
few providers are uncertain about a decreased prevalence. The community leaders were similarly divided on whether or not HIV prevalence is decreasing or increasing. However, those who indicate a decreasing point to ART use, which has improved the well-being of those living with the virus; they, however, fail to explain how ARVs used by those already infected can lead to decreased infection.

**Gender Inequality and Vulnerability to HIV and AIDS**

Discussions of the influence of gender relations on vulnerability to HIV and AIDS brought various views and reactions on who or what category of people are considered to be more vulnerable. Variables mentioned as important include gender, age, literacy, socioeconomic status, marital status, and religion. Figure 1 below shows that all groups believe that the female are more vulnerable to HIV. The youth group rated the vulnerability of female highest (34.4%). In terms of age, the youth 29(18.8%) were also considered as vulnerable while wealth and poverty were rated the same 19(9.7%) in vulnerability to HIV: the rich, whose vulnerability is driven by economic power buy sexual favours or by lack from the poor, which reduces the latter's negotiating power for safe sex as the balance of power rests with the buyer. The adults also identified female 43(23.9%) as being most vulnerable. In addition, they said that differences in religion exist, with higher prevalence 28(15.6%) among Christians, which is largely attributed to greater casual sex across faiths by Christian girls, while youth 27(15.0%) are also seen as vulnerable.

Christians are more outgoing and their wives do not practice women seclusion. Except for those who have some knowledge about the biological composition of male and female, the reasons proffered for vulnerability were based on participants’ observation and opinions on the prevalent social interactions and networking in society.

Women are generally believed to be more vulnerable to HIV as victims or culprits for a variety of reasons. The notion of women as victims contradicts the beliefs that women are the vectors of diseases and sources of infection to men or their unborn children. Women's vulnerability as victims is due to gender inequalities where men exert greater power in the relationship between men and women, evidenced by the tacit acceptance of men's infidelity and risky behavior, which increase the vulnerability of their partners to HIV.

Religious practices and cultural values that approve polygamy and extramarital relationships were identified by participants in Chanso, Bukuru, Kunga, and Kuru as increasing the vulnerability of women. The situation is complicated by the general lack of interest in HIV testing. As a respondent explained 'People won't even go for test—IIt is a situation of—if I have it and I have two wives and I have a girlfriend who has it, you will spread it to others' (FGD, Male Youth, Chanso).

Religion influences marriage norms to increase women's risks; Islam permits marriage of up to four wives. In addition, men have more access to knowledge and information especially in Islam where men move about freely, a privilege not enjoyed by their wives in seclusion (purdah). Sometimes the men withhold life-saving information from their wives, through non-disclosure of their serostatus, which increases the women’s vulnerability and suffering. There are several instances where men were said to infect their wives while secretly receiving ART. Respondents reason that women have weaker blood and may die quicker. There were frequent references to women's weak blood and men's strong blood which protect them from infection or living longer when infected.

A few respondents point to biological differences between male and female as accounting for women's greater vulnerability, such as the wider and moist female sexual orifice. However, some had the erroneous view that women can get infected from toilets. A few others even said the menstrual cycle itself increases the vulnerability of female due to the monthly loss of blood and inadequate nutritious food, in a resource-constrained setting with low living standards.

Women's agency in increasing their vulnerability to HIV infections was also canvassed with the respondents. The females are reported to face double vulnerability, which is attributed to their behavior as well as the predominant gender relations: 'Women get HIV from the men and go out themselves to get infected (FGD, Female Youth, Kuru). Another female participand re-echoes this: 'some married women are not left behind' (FGD, Female Adults, Apata). They also get the infection from husbands whose philandering is generally condemned in the community.

The quest to conform, modernity and means of sustaining the lifestyle have been attributed to the greater vulnerability of young girls by some participants. Some girls are said to actively seek men out, particularly CSWs, which creates a chain of vulnerabilities. Women are also described as being covetous, or in the words of an FGD discussant 'Women have kodeyi (a covetous nature), when he gives her small money she dances to your tune' (FGD, Adult Males, Chanso). There is little appreciation of women's powerlessness in avoiding infection. Gender inequalities reduce the power of the woman to negotiate safe sex and poverty would cause the desperate woman to dance to the tune of a man for 'small money'.

Younger girls were generally viewed by all groups to be more vulnerable. This is because some engage in transactional sex due to the desire to acquire material possessions that are above their means but symbolize modernity, such as smartphones to enable participation in social media, paying for expensive hairstyles and keeping up with clothing fashion.

Most female youths who engage in transactional sex normally do so outside the home for more anonymity. In the discussion, young men employed football (soccer) parlance to describe such female: 'It (HIV) mostly affects young ladies, they mostly go for “away matches” and one morning she will come back with sickness’ (FGD, Male youth, Bukuru). The urban environments they relocate to be usually characterized by secondary relationships, anonymity and the opportunity to hide their lifestyles from their significant others. The young ladies who adopt such lifestyles eventually lose out as is commonly believed in football games, in ‘away matches' the absence of support of the home crowd may determine the gains outcome. When the consequences of such lifestyles catch up with...
them, they invariably return home infected and ill with HIV to family and friends, who are then saddled with the burden of providing care. A participant succinctly describes the rate of vulnerability based on age in a descending order: Everybody: The youths are more likely because of their sexual practices. All young people contract it, then sugar mummies and sugar daddies before the grandparents because they don’t have the strength to have sex. But they can also get it through needles and blades (FGD, Female Youth, Apata).

Opinions were sharply divided on vulnerability due to socio-economic status. Some participants considered the poor as the greatest victims of such sexual relationships. For those who felt the poor are more vulnerable, the dependence on wealthy benefactors who demand sex in exchange also exerts greater power in such relationships. The poor continue in risky sex to meet basic needs and thereby reinforce the belief as the vectors of the virus.

Most of the community leaders said that youth, particularly female and women in general, are most vulnerable to HIV due to their promiscuous lifestyles and covetousness. Some hold the view that women’s vulnerability is caused by women who infect them in the first place. The position of health service providers is similar. They also mentioned that when antenatal clinic attendees test HIV positive, their husbands may already know their own status and even have started ARV treatment but keeping the wives in the dark. The general consensus is that women are more vulnerable and young women are the most vulnerable.

Discussion

The study shows how issues of gender, power, and poverty are important factors in HIV vulnerability. As shown, gender inequalities increase vulnerability to HIV and AIDS in Plateau state. Most of the respondents in this study (77.5%) are within their reproductive and or sexually active ages; they are therefore able to relate to the issues under study. The older population are able to give their general perspectives on the issues being discussed from a different generational perspective. There frequent references to how things have changed from the previous generation which was more “proper” and less open in sexual matters.

It was found that many blame ART for increasing the risk of HIV infection. This opinion about ARTs attests to poor behavior modification in spite of awareness campaigns against casual, multiple partner and unprotected sex, there is still a reliance on physical appearance rather on HIV Counselling and Testing (HCT) in the selection of sexual partners. Gender stereotyping of the female as vectors of HIV was implied in some groups, referring to the ‘fine looks’ of infected people (as a result of ART), that predispose ‘married men’ to seek out relationships with them and thereby risking infection. Some of these married men who are known to have infected both their wives and the young girls, take ARTs secretly [29]. This is similar called for more behavioral research on PLWHA with access to ART who now perceive HIV as an chronic disease, and engage in unrestrained sexual behavior that fuels transmission. There is limited awareness of the usefulness of ARTs for the future socio-economic stability of the country, thus people blame rather than hail the availability of ARTs in stabilizing the pandemic.

Most of the respondents do not have authoritative information on HIV prevalence, particularly HSS reports of the Federal and State Governments and other agencies. The low literacy levels in the country as well as unavailability of Information, communication technology (ICT) services to the majority of the populace who reside in rural areas could partly explain this. Nigeria’s 60% literacy rate among people 15 years and above is lower for female (http://en.unesco.org/countries/nigeria).

The poverty levels are relatively high, particularly among women and young girls. Their higher poverty levels increase vulnerability to HIV in transactional and or love relationships due to their economic dependence on the men. Such dependence gives the men greater power in making decisions about the nature and conduct of sexual relationships, which are still risky as evidenced in the high prevalence rates in the state and the general low condom use, particularly in marital relationships. Respondents reveal that married women’s vulnerability is as a result of men’s multiple sexual partnerships (marital and casual) that are culturally acceptable, against which women are powerless to resist.

The situation has been accelerated with increased urbanization. Urbanisation was initially male-dominated and this changed the pattern of sexual behavior as men may also use the services of commercial sex workers and other unmarried women in transactional relationships, in the absence of their regular partners who were still in the rural areas. This pattern of urbanization was recorded in the founding and construction work in Abuja, Nigeria’s capital which was formerly in Lagos [30]. The further changes in family structures and the loosening of social control witnessed a further permeation of casual sex in the society, even among those in monogamous marriages. However, the beliefs that men have ‘naturally’ large sexual appetite which is not satiated by one sexual partner leaves little room for the behavior change required for prevention of HIV. Furthermore, the poor and inconsistent usage of condoms as protection increases women’s vulnerability once the man engages in casual sex, where condom use is rarely negotiated and safe sexual partners are assessed more on the basis of physical appearance. This supports the finding of Onwuliri et al. [21] on marriage being the greatest risk factor for women in contracting HIV because multiple partners for the man is widely accepted, with and without safe sex.

Furthermore, the study shows that the youth are more vulnerable to HIV than the adults. This is due to greater indulgence in casual and multiple sexual partnerships. The increase in alcohol and substance use among the youth was further identified as responsible for greater casual sex. However, the vulnerability of the female youth was considered higher as they engage in cross-generational sex with men who have longer sexual histories and might already be infected; they are also in relationships in which they are unable to negotiate for safe sex. Most of such relationship is for material gains to sustain the modern lifestyle.

It is generally understood that some of the young girls travel to bigger cities to secure livelihoods through sex work. Some have been reported to fall victims of sex traffickers and even travel abroad, and may return home ill. These views are consistent with data that show the prevalence of HIV among women in Nigeria; particularly female youth is higher [31]. The findings are also similar to liberal Feminist perspective that locate the inequalities of women in society in their predominance in the private sphere and in low income, low-status occupations, which we have found in this study to increase vulnerability and reduce women’s capacity to prevent HIV.

There is an overall acceptance that people in this generation are having more sex, some of it, unprotected. The increase in sexual activities is rendered by respondents in the moral term; the common terms used are moral decadence, immorality, and promiscuity. They, however do not factor in the gender dimensions in this seeming immorality.

Based on the findings, redressing gender inequalities as a means of mitigating HIV prevalence in Plateau State to achieve primary prevention in the general populace and among PLWHA still, poses a major challenge. Structural and interpersonal impediments persist as patriarchal power relationships still account for women and
young girls’ vulnerability. The high poverty levels in the country particularly among female and the gender gap in education place women at a disadvantage in competing for scarce employment opportunities as well as the absence of an enabling and secure environment for trading or other forms of self-employment continue to account for higher levels of poverty and powerlessness among female and youth. The continuation of multiple partners and or casual sex, and the use of physical appearances to decide safe sexual partners rather than utilizing barrier methods or HCT to avoid infection put to question the effectiveness of prevention efforts employed so far.

We conclude by noting that the fight against HIV/AIDS would continue to achieve limited results without attending to the structural issues with which the epidemic occurs. A comprehensive plan that addresses the gender gaps and HIV vulnerability through legislation and budgetary allocations to critical sectors of education, health and job creation needs to be enforced. In addition, engaging all stakeholders to bring about change in beliefs and practices that threaten collective vulnerability holds the key to more effective intervention.

References


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Received Date: August 07, 2017, Accepted Date: October 16, 2017, Published Date: October 26, 2017.

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