

# **CULTURAL DIMENSIONS IN POPULATION RELATED ISSUES IN NIGERIA: IMPLICATIONS FOR PLANNING POPULATION INTERVENTION PROGRAMME**

**SHOFOYEKE, A. D.**

National Institute for Educational Planning and  
Administration (Nigeria), Ondo  
E-mail: shofoyekeng@yahoo.com

## **Abstract**

Culture as a way of life determines to a large extent human behaviour. It is patterned, learned, shared and adaptive and transmittable from one generation to the other and has a way of influencing everything we do. It can be perpetuated and has a potential to overpower intervention programmes, social and educational motivations. In view of these, this paper examined some cultural dimensions of population issues with particular reference to cultural factors and population, cultural construction of HIV and AIDS, population policy implementation strategies and implications for planning. Cultural practices, norms, values, beliefs and religion negatively influence procreation, population control measures, immunization, child survival transmission, management, child survival transmission, management and care of HIV and AIDS. Traditional beliefs about the value of children, particularly preference for sons, polygamy, widow inheritance, child marriage, female circumcision, gender-based violence, male dominance in decision making regarding sexual determination and choice of family planning, stigmatization of People Living With HIV/AIDS (PLWHA) are also culturally induced to some extent. The paper suggests that cultural practices beliefs and values be taken cognizance of in developing and implementing population policy by involving community leaders and representatives of other stakeholders.

**Keywords:** Cultural dimensions, population related issues, cultural practices, values and norms, implementation strategies.

## **Introduction**

Culture, like any other social science concept varies in definition and meaning depending on the perspectives and background of who is defining it. Cranfield School of Management (2010) described culture as a pattern of responses discovered, developed, or invented during the group's history of handling problems which arise from interactions among its members, and between them and their environment. These responses are considered the correct way to perceive, feel, think, and act, and are passed on to the new members through immersion and teaching. Culture

determines what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable. It encompasses all learned and shared, explicit or tacit, assumptions, beliefs, knowledge, norms, and values, as well as attitudes, behaviour, dress, and language. In this case, culture is viewed from business perspective but which is also true of organizational and social culture. This agrees with Olurode (1989) who described culture as a 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. According to dictionary.com, culture can be defined as "the behaviours and beliefs characteristics of a particular social, ethnic, or age group".

Knowledge of the meaning of culture might aid our understanding of other people's actions, behaviour or thinking relating to population related issues. For instance, the attitude of Yoruba, Hausa, Igbo, Christian or Muslim towards marriage, procreation, preferences for male child, nutritional habits can be predicted once his/her cultural background is mentioned or known.

Through culture, people and groups define themselves, conform to society's shared values, and contribute to society. Thus, culture includes many societal aspects: language, customs, values, norms, mores, rules, tools, technologies, products, organizations, and institutions. This latter term, institution refers to clusters of rules and cultural meanings associated with specific social activities. Common institutions are the family, education, religion, work, and health care.

Roshan Cultural Herital Institute (2001) states that culture is collectively defined in terms of language, arts and sciences, thought, spirituality, social activity and interaction. It suffices to say that culture affects development and developmental efforts. In the same vein and on the basis of the Mexico Declaration of 1982, culture is broadly understood within UNESCO to include: ways of life, traditions and beliefs, representations and health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communication and arts and creativity.

These features of culture such as traditions and beliefs representations and health and disease, sexual norms and practices, family structures, way of life have implications for fertility, nutritional habits, child survival and mortality, acceptance of population control measures and emerging issues in population such as HIV/AIDS.

The ultimate objectives of this paper are to examine:

- How cultural factors influence population related issues;
- The extent culture influences HIV/AIDS prevention, care and support;
- The impact of culture in population policy implementation strategies; and implication of cultural factors in planning population related interventions.

### **Cultural Factors and Population**

In contemporary society, population has become an important issue of concern because its size and composition has far-reaching implications for change in development and quality of life in society. Although it took over a century for the world to mark the first billion, population growth has been significant to the extent that the period to add billion people has been less than fifteen years in recent time. For

instance, the world population rose from 4.8 billion in 1985 to 6.4 billion in 2004: an increase of 1.6 billion within 19 years (United Nations, 2001b; Population Reference Bureau, 2004). As at March 12, 2012, it was estimated to number 7.045 billion by the United States Census Bureau (USCB). It is estimated to reach 10.5 billion by 2050. Approximately 4.06 billion people live in ten countries, representing around 58% of the world's population as of April 2012. Nigeria ranks 7<sup>th</sup> position in the world largest most populous country which has population of 170,123,740 representing 2.41% of the world population as at July 2012. Also in Nigeria, the total population was recorded as 162.5 million people in 2011 from 45.2 million in 1960, changing 260 percent during the last 50 years (Trading Economics, 2012). The population of Nigeria represents 2.35 percent of the world's total population which indicates that one person in every 43 people on the planet is a resident in Nigeria.

Factors responsible for increasing population growth and population related issues are discussed under the following sub-headings:

- (a) *Traditional beliefs* Although population growth is attributable, on one hand, to improvement in human survival associated with the application of modern medical science to health matters, better sanitation and immunization of children, which have caused the death rate to decrease (Ashford, 2001; United Nations, 2001a). There are cultural issues that are attributable to traditional beliefs about the value of children, particularly sons, as an asset to be relied upon by their parents in agricultural production and to support them during old age have combined with the practice of polygamy, the fear of child mortality and low levels of female education to encourage high fertility (Onwuka, 2005). Furthermore, the continuity of the patrilineal decent group and the influence of religions, which teach that children are gifts from God sharply limits the prospects for lowering the birth rate (Miller, 1990; Renne, 1995; Ainsworth et al, 1996).
- (b) *Religious factors* Many religions promote large families as a way to further the religion or to glorify a higher power. University of California (2009) cited example of Orthodox Judaism which encourages large families in order to perpetuate Judaism. Roman Catholicism promotes large families for the same reason, and forbids the use of any "artificial" means of birth control. Devout followers of a religion with such values often have large families even in the face of other factors, such as economic related and respect for having high number of children. Nigeria also has large population partly because of the presence of the two religions, and other factors. For example, the 1988 Nigeria National Policy on Population was rejected by a number of Christian churches due to bias of reducing the number of children from 6 to 4 per woman (Ejizu, 1990). The policy favours Muslims since they uphold the practice of polygamy. In the face of such a religiously motivated opposition, the expectations of curbing the rate of fertility in Nigeria with policy remain dim.

Zimbabwe is also a country with a similar practice. For example, Catholic Bishops and lay leaders in Zimbabwe publicly voiced their opposition to the agenda of the 1994 International Conference on Population and Development. Their media campaign in the weeks prior to the conference sparked public debate about reproductive rights, the role of the family, and adolescent sexuality (Bishops Hit Out at Population Agenda. The Daily Gazette, 17 August 1994; The Herald, 1 September 1994). Similarly, immunization was first rejected in some part of Northern Nigeria due to fear of unknown.

- (c) *Diversity of Environment and Culture* The local cultural milieu of Nigeria is extremely diversified, and depends not only on the ethnic cultural values and habits, but also on religious habits and obligations. There are also major differences between rural and urban cultural life, and rural and urban habits and norms. In Nigeria, the National Population Commission (2004) identified some cultural norms and practices that affect the health of women and children and influence fertility and childbearing practices. Examples include polygamy, son preference, widow inheritance, child marriage, female circumcision, bride price, property inheritance, land tenure practices, gender-based violence and child labour. These practices have far-reaching effects on population and quality of life.
- (d) *Factors affecting women or gender issues* Various factors involving women can also affect family sizes. These include education and employment opportunities available to women, the marriage age of women and the social acceptance of birth control methods. These factors are sometimes strongly influenced by society's cultural attitudes towards women. While population control measures have been successful in other regions including Asia due to aggressive campaigns, for small family size, development and implementation of population policy. Similar efforts have gained momentum in sub-Sahara Africa but have not been too successful due to prevalence of socio-cultural practices. Such practices include early marriage, wife inheritance, family beliefs about sex and concentration of health facilities in urban areas, inadequate access to health facilities by rural populace. Population control programmes tend to be directed more to women. It appears that the roles of men in contraceptive decisions and cultural practices influence are ignored which might lead to low achievement of population intervention efforts.
- (e) *Problem of Patilineality* The Hausa society in Northern Nigeria is patrilineal with strong male influence on many household decisions including those involving reproduction. This makes the attitudes of male toward family planning and contraceptive use a significant factor influencing the over all fertility level in the region. The roles men play as household heads, custodians of their lineage and providers for their family, decision making power within the family and society largely lies with men (Isiugo-Abanihe, 1994). Evidence from study on family planning practices supports this. Reports of survey of male knowledge, attitudes, and family planning practices in Northern Nigeria by Duze and

Mohammed (2006) showed that there is high knowledge of contraceptives, but a generally negative attitude towards limiting family size for economic reasons, and consequently low rates of contraceptive use. Men who were willing to use contraceptives were more willing to use them for child spacing purposes than explicitly for limiting family size.

- (f) *Lack education* Lack of education and awareness create a problem. Apart from relatively low rate of adult literacy (68%) in Nigeria, ignorance and low awareness play significant role in acceptance and use of contraceptives and other preventive measures. Education has the largest direct and total effects on contraceptive use while specific knowledge of contraceptive has the smallest direct and total effect.
- (g) *Cultural Differences* Culture also has impact on population policy in that cultural environment is significant in implementation strategies and achievement of targets and goals. The culture experienced by present-day policy makers affects their development of strategies for the future (Schneider, 1989). Azefor (1989) argues that the lack of attention to cultural religious, and social factors in sub-Saharan Africa caused planners to overlook local priorities and thus contributed to low national commitment to population policies.
- (h) *Social Assumptions* Gage and Njuogu (1994) highlighted the gaps in social assumptions underlying family planning programs and local realities. These scholars cited Bleek (1987) who observed that the family planning program in Ghana was criticized for disregarding the complex nature of family organization, particularly the matrilineal tendencies in childrearing. The initial program was based on implicit assumptions that fathers are household heads, marriages are stable, and that marriage is the main context for procreation, thus excluding a focus on premarital or extramarital pregnancies.

### **Influence of Culture on the Spread, Prevention, Care and Support of HIV/AIDS**

It is no longer news that HIV prevalence in Nigeria reduced from 5.8% in 2003 to 3.1% in 2009 (Federal Ministry of Education 2005; Central Intelligence Agency World Factbook, 2009). Also, based on 2009 estimate, Central Intelligence Agency (2012) puts adult HIV/AIDS prevalence rate at 3.6% and number of people living with HIV/AIDS as 3.3 million. This indicates a slight increase in the prevalence rate in spite of the various intervention efforts. However its impact on all facets of the economy remains. Its spread, management and prevention have gender, cultural and socio-cultural, and ignorance dimensions.

- (a) *Gender, cultural and socio-cultural dimensions* In Yoruba traditional society and in some parts of Africa, a number of cultural practices such as *Ikobirinjo* (polygamy), *Isupo* (levirate or wife inheritance) and *Idabe fun obirin* (female circumcision) have been identified as having tendencies to facilitate the spread of HIV. Although a muslim by rite can marry more than one wife while Christianity encourages marrying one wife but a good number of Christians have concubines (*a/e* in Yoruba) which translates to multiple sex. Since sex is regarded as secret, level of trust among couples and mistresses is a concern for spreading of HIV (Akanmu, 2004). Although the practice of wife inheritance declines with western education, however the practice is still prevalent in rural areas and among the illiterates. According to Oyekanmi (1995) the prevalence of patriarchy and widespread practice of polygamy 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 relationship, child care and health seeking practices are explored with a view to linking their relation to the possible transmission of HIV/AIDS. Traditional practices relating to sexual relationship, wife inheritance, condom use, male dominance in sexual determination, ignorance, screening for HIV and counseling are all affected by culture and customs. Among many ethnic groups in Nigeria particularly the Hausa, wife must seek the consent of the husband before going to hospital, undertake HIV test or promote HIV/AIDS awareness among peers. In Akwa-Ibom State Nigeria (Modo & Enang, 2010) found that people's belief system and socio-cultural practices favour the contracting and spread of HIV/AIDS

Mbonu, Borne and Vries (2009) stated that there exists an association with specific sexual behaviour that is considered socially unacceptable by many people contribute to the stigma associated with HIV Infection. HIV/AIDS provides an example of how illness, despite the biological characteristics of its signs and symptoms, always carries a second reality expressed in cultural images and metaphor (Goldin, 1994; Mawar, Saha, Pandit & Muhajan, 2005; Wood and Lambert, 2008; and Uys, Chirwa, Dlamini, 2005). According to Campbell (2005) even when ART is available and the outcome of HIV/AIDS not always fatal, the link between HIV/AIDS and bad (sexual) behaviour is still a concern for PLWHA because of shame and embarrassment (Campell, Nasir, Maimane & Nicholson, 2007). Fears associated with illness, disease and sex therefore need to be viewed in their broader social and cultural context. The unacceptability associated with the disease reflect in terms such as "a long illness" or "a short illness" are deemed culturally acceptable in the obituary of someone who dies from HIV/AIDS rather than mention of the real cause of death Golden (1994). In a study in Zimbabwe by Duffy (2005), denial and miss-attributions of HIV/AIDS cause (e.g. witches, unhappy ancestors, etc) were common. Less than exact terms are also used by people, including health care professionals to describe HIV/AIDS to avoid insensitivity to culturally sensitive issues but not necessarily deny HIV/AIDS. For example, health care professionals in Malawi call it *ELISA* disease, immunosuppressant, and so forth, or lay people calling it *Kaliwondewonde* (slim disease), *Ntengano* (the

disease that leads to wife and husband dying together or one after the other) Muula & Mfutso-Bengo (2005). In Nigeria, HIV/AIDS is stigmatizing because it carries many symbolic association with danger, attribution of contagion, incurability, immorality and punishment for sinful acts is common in many societies.;kgpi (Campbell, Nursir, Maimane and Nicholson, 2007; Gilmore and Somerville, 1994; Hardon, Otolok –Targa, Atuyambe, Mosphy, Ringheim and Woldehanna, 2007). Another initial bias is that a person diagnosed with HIV is perceived to be immoral. Quam (1990) argues that beliefs about AIDS as a “polluted disease” reflect people’s negative evaluation of the routes through which HIV enters the body.

Sexually transmitted infections are considered to be agents of contamination or pollution in a study about HIV/AIDS prevention among African traditional healers (Kalichman, Simbayi & Jooste, 2005). This polluting quality of AIDS and fear of the disease are translated into stigmatizing responses such as avoidance and isolation Self-diagnosis and self-treatment remain widespread (Chimwaza & Watkins, 2004) owing to stigmatization. The pursuit of different therapeutic options is sometimes a result of the problematic social complexity linked to AIDS. Witches and witchcraft remain an option for self-diagnosis of illnesses (Hartwig, Kissioki & Hartwig, 2006) as well as for diagnosis by traditional healers. Common people say that HIV/AIDS hides behind witchcraft since it is more culturally acceptable and it avoids personal shame Duffy (2005). People prefer to claim that they are bewitched or have (normal) tuberculosis rather than accept that they have HIV/AIDS (Wood & Lambert, 2008).

Among the Yoruba tribe in Nigeria, HIV infection is attributed to sexual poison called *magun* which can be cured by herbalists (Oyekanmi, 1995). However, there has not been any successful reported case of treatment through this effort.

(b) *Ignorance* In this context, it is common to observe that when someone has been diagnosed with the HIV/AIDS virus in Nigeria, some people believe the disease has somehow filtered through the blood system of the sufferer’s family members. This is how ignorance fuels the belief that health-related illnesses, in particular terminal diseases, have consequences beyond the sufferers. HIV/AIDS victims and their families are isolated in public and also experience discrimination. In closely-knit traditional societies, isolation constitutes a severe form of punishment. Lack of belief in the existence of HIV/AIDS is a major obstacle against its intervention efforts such as campaign, checking on the status, among others (Obijiofor, 2010).

### **Population Policy Implementation Strategies**

The National Population Policy targets at achieving reduction of the national population growth rate to 2 percent or lower by the year 2015 (Federal government of Nigeria, 2004). Others are:

- Achieve a reduction in the total fertility rate of at least 0.6 children every five years.
- Increase the modern contraceptive prevalence rate by at least 2-percentage point per year.

- Reduce the infant mortality rate to 35 per 1,000 live births by 2015.
- Reduce the child mortality rate to 45 per 1,000 live births by 2015.
- Reduce maternal mortality ratio to 125 per 100,000 live births by 2010 and 75 by 2015.

One of the ten strategic areas of implementing Nigeria population policy deals with the socio-cultural barriers and need for legal support. This indicates that the policy states "certain cultural beliefs and norms in Nigeria violate the reproductive rights and are harmful to the reproductive health of individuals, especially girls and women. These include early and forced marriage, female genital cutting, widowhood rites and gender-based violence" (FGN, 2004: 43).

To address these challenges, the policy strategies include appropriate legislation to be enacted and enforced to eliminate all harmful practices, including early marriages, female genital cutting and violence against women; protect the family and the institution of marriage by raising the age at first marriage to at least 18 years for females; review, revise and enforce under-age females from sex abuse and exploitation; promulgate law to ensure that men provide paternal support for any child(ren) they father; intensive behavioural change communication programmes to be undertaken at the National, State and Local levels to raise awareness about child marriage and other harmful practices and appropriate behavioural change and advocacy efforts targeted at leaders at all levels to facilitate the elimination of harmful practices and the removal of socio-cultural barriers to good productive health, shall be strengthened.

In addition to these, other main strategies have components of advocacy, behavioural changes, limiting negative impacts of socio-cultural and religious practices. Instances of these are:

First, population data indicate that most of the strategies aimed at achieving population policy targets are not yielding desirable results if they are ever implemented. United Nations (2008) puts Nigeria annual population growth rate as 2.5% whereas Central Intelligence Agency (2010) puts the figure as 1.999% in 2010 and 2.55% in 2012 (CIA, 2012). Although the later might be questioned, a growth rate of 2.5% in 2008 may reduce to 2.0% in 2015, a period of 7 years, if more conscious efforts are made in that direction.

Second, in 2004, total fertility rate was 5.2 and five years later it was expected to be 4.6 and further reduced to 4.0 in 2015. National Demographic and Health Survey conducted by National Population Commission (2008) puts total fertility rate at an average of 5.7 children per woman and women in rural areas may give birth to more children than the national average. CIA (2010) puts an estimated total fertility rate in 2009 as 4.91 and 5.38% in 2012 based on 2011 estimate (CIA, 2012) which is higher than the expectation or target of 4.6. Thus, the target of reducing fertility rate by at least 0.6 children has not been achieved and may not be achieved in the nearest years ahead. It suffices to say that the demand for children may not considerably decline partly due to cultural practices of having preference for son or desire to have female if other children are male or the fear of unknown.

Third, the Federal office of statistics (2009) reported infant mortality of 94.35 deaths/1000 live births in 2009. A breakdown by gender shows 100.39 deaths/1000 for male and 87.97/1000 for female. This ratio reduced to 79.44 deaths/1000 live births for male and 68.97 deaths/1000 live births for female (CIA,2012) To reduce this figure to 35/1000 live births in 2015 might be difficult. This indicates that apart from inefficient health delivery system, cultural practices on nutritional habits, hygiene, preventive health are still been influenced by socio-cultural practices. Childhood diseases such as malaria, acute respiratory tract infections, diarrhea and vaccine preventable diseases like measles, tuberculosis, diphtheria, whooping cough, polio and tetanus constitute the bulk of morbidity. Most infant and child deaths occur as a result of these diseases. Malaria alone accounted for an estimated 300,000 deaths among children each year (UNICEF, in the Nation: April 30, 2010).

Although about 15 percent family has access to mosquito nets, its usage by children and pregnant mothers is being affected by ignorance and illiteracy. In a survey of mosquito net usage in 2010 in Ogun State Nigeria, a health officer in a local government reported that some rural community leaders collected the nets in the villages together and burnt to serve as rituals to ward off evil. It was the belief of the villagers that the net will bring evil spirit to the children, mothers and the villages at large. All said and done, the foregoing has planning implications for population related programme interventions.

### **Implications for Planning Population Intervention Programmes**

Increasing population growth and its attendant challenges as well as emerging population related issues such as HIV/AIDS, gender issues, genital mutilation, have necessitated conscious efforts in addressing them with a view to mitigating their impact. The intervention efforts are routed through development and approval of national policy on population and implementation of programmes. However, issues relating to population are often highly laden with emotive, cultural and religious biases which call for careful approach. Moreover, religious groups, traditional rulers and opinion leaders can hold sway over issues such as population control measures, immunization, health issues relating to population management and interventions in population related emerging issues and policy which may appear to question, challenge or conflict with their long-held cultural and traditional values. Culturally accepted population interventions could alter adherence to traditional and religious values, beliefs and practices.

Understanding what motivates peoples' behaviour, knowing how to address these motivations appropriately, and taking into consideration peoples' cultures when developing population programmes are essential to changing behaviour and attitudes towards population issues. Thus, this calls for a population rights approach to development planning that places people at the heart of development. Planning and implementation of Population policy, population control measures, HIV/AIDS and Family Life Education and other population related programmes require due consideration for people's culture and religion.

Culture should be taken into account at various levels in planning and implementing population policy. The cultural context constitutes an environment in

which population communication and prevention education takes place should be considered in policy development and implementation. Similarly, taking cognizance of culture within the content of population issues may help in generating ethical motives for guiding the evolution of local cultural values and resources that can influence prevention education; culturally appropriate content of sensitization messages is mandatory for them to be well understood and received by the target population. Also, using culture as method of presenting population issues legitimates social practices which can be useful in enabling peoples' participation, and which can be harnessed to help ensure that population programmes, HIV/AIDS prevention and care is embedded in local cultural contexts in a stimulating and accessible way.

There is need to tract implementation of the population policy through research to determine if the targets can be achieved as planned. In doing this, cultural and socio-cultural factors militating against the achievement of the targets can be addressed.

### **Conclusion**

Culture has influence on all shepherds of life, weather indigenous or imported. All population related issues are influenced by one cultural practice or the other because man is part of a society. Child bearing, child survival, acceptance or rejection of modern family planning, immunization of children against deadly diseases, inheritance practices, attitudes to HIV and AIDS transmission, prevention and cure, have cultural dimensions norms and values. It is therefore suggested that all population programmes and policy should involve community representatives, religious and opinion leaders in planning and implementation. Although advocacy for behavioural changes is desirable, it could be more effective if community leaders and representatives of beneficiaries are included to plan and implement with them and not for them.

### **References**

- Akanmu, D. (2004). Marriage cultural practices, HIV/AIDS and Socio-Economic Development in Africa: The Yoruba Example. *Journal of Constitutional Development*. 4(1): 94-106.
- Ashford, L.S. (2001.) New Population Policies: Advancing Women's Health and Rights, in *Population Bulletin* 56(1): Washington, Population Reference Bureau.
- Bleek, W. (1987). Family and Family Planning in Southern Ghana in Oppong, C. (ed), *Sex roles, Population and Development in West Africa*. London: Heinemann
- Campbell C., Foulis C. A., Maimane S., & Sibiya Z., (2005) I have an evil child at my house: stigma and HIV/AIDS management in a South African community," *American Journal of Public Health*, 95 (5): 808–815.
- Central Intelligence Agency (2010). Nigeria People World Faitbook, United States. <http://www.theodora.com>

- Chimwaza A. F. & .Watkins, S. C (2004.) Giving care to people with symptoms of AIDS in rural Sub-Saharan Africa, *AIDS Care*, 16 (7): 795–807
- Cranfield School of Management (2010). Overview of culture [www.som.cranfield.ac.uk/scm](http://www.som.cranfield.ac.uk/scm)
- Duze, M.C & Motiammed, I.Z. (2006) Male knowledge, Attitudes and Family planning practices in Northern Nigeria. *African Journal of Reproductive Health*; 10 (3): 53-65.
- Ejizu, C.I. (1990). Religion-Cultural Issues in population Growth in Nigeria. *Africana Marburgensia*. 23(2): 36-47
- Federal office of statistics (2009). Annual Abstract of Statistics. Abuja, Federal office of statistics
- Goldin C. S., (1994). Stigmatization and AIDS: critical issues in public health, *Social Science and Medicine*, 39.(9): 1359–1366.
- Hartwig, K. A; Kissioki, S. & Hartwig, C. D. (2006) Church leaders confront HIV/AIDS and stigma: a case study from Tanzania, *Journal of Community and Applied Social Psychology*, 16 (6): 492–497.
- Mbonu, N.C; Bart Van den Borne, N.K. & De Vries (2009). Stigma of people with HIV/AIDS in Sub-Saharan African: A Literature Review. *Journal of Tropical Medicine* volume 2009 Article ID 145891.
- Modo,I.V.O; Modo, F.N. & Enang, P.I. (2010). Socio-Cultural Factors Responsible for Increasing Rate of HIV/AIDS in Akwa-Ibom State of Nigeria. [www.krepublishers.com/02-journal/s](http://www.krepublishers.com/02-journal/s)
- National Population Commission (2004). *National Policy of Population for sustainable Development*. Abuja, National Population Commission.
- National population Commission (2008). *National Demographic and Health Survey*. Abuja, National Population Commission
- Obijiofor, L. (2010). Living with Ignorance over HIV/AIDS. [Nigeriavillagesquare.com/articles/g](http://Nigeriavillagesquare.com/articles/g)
- Olurode, L. (1989). *Socio-cultural practices and population behaviour in Nigeria with particular reference to Lagos State*. Paper presented at the population seminar for principals of pilot schools and population education committee members March 31, 1989.

- Onwuka, E.O. (2005). Another look at the impact of Nigeria's Growing Population on the Country's Development. *African Population Studies*. Vol. 21n/
- Otolok-Tanga E., Atuyambe, L., Murphy, C. K., Ringheim K. E., and S. Woldehanna, (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: a case study of Uganda, *African Health Sciences*, vol. 7, no. 1, pp. 55–60..
- Oyekanmi, F.A.D. (1995). *Socio-cultural relations in the Nigerian family. Implications for AIDS in African*. Paper presented at the IX<sup>th</sup> annual conference of the population Association of Nigeria, Benin City, Nigeria
- Population Reference Bureau (2004). *2004 World Population Data Sheet of the Population Reference Bureau*, Washington, Population Reference Bureau
- Quam, M. D. (1990). The sick role, stigma and pollution: the case of AIDS, in *Culture and AIDS*, D. A. Feldman, Ed., pp. 29–44, Praeger, New York, NY, USA.
- Renne, E.A. (1995). Houses, Fertility and the Nigerian land Use Act, in *Population and Development Review*, 21(1): 75-90
- Roshan cultural Heritage Institute (2001). Culture and society. <http://eridan.Websrvcs.com/console>
- The Nation (2010). *New Extra; 'Malaria Still Prime Child Killer in Nigeria'* Lagos, Vintage Press Limited. April 30, pp 27.
- United Nations (2001a). *Population, Environment and Development: The concise Report*. New York, United Nations.
- United Nations (2001b). *World Population Prospects: The 2000 Revision, Vol. 1. Comprehensive Tables*, New York, United Nations.
- University of California (2009). Population Growth. University of California, College of Prep. *File:///c:/population Growth. xhtml*