

Full Length Research Paper

Youth attitude to some human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) preventive measures in some institutions of higher education in Nigeria

Adegoke S. AJIBOYE

Department of Statistics, the Federal University of Technology, Akure, Ondo State, Nigeria.

Accepted 23 October 2013

Youth attitude to some human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is a world-wide epidemic that has given governments around the world sleepless nights. The case of sub-Sahara Africa is particularly worrisome. More than half the world cases are believed to be in this region. Nigeria as one of the countries in this region is not spared the devastating spread of the virus and young people are particularly vulnerable. This research focused on attitudes of young people towards some preventive measures of HIV/AIDS transmission in some tertiary institutions in the southern part of Nigeria. Samples of size 50 were randomly taken from four institutions and the data obtained were tabulated and analyzed using the chi-square test. It was discovered that response to these measures is poor. Majority of the youths are aware of the preventive measures but they appear to be indifferent to them.

Key words: Attitude, preventive measures, Youth attitude to some human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), institutions of higher learning.

INTRODUCTION

Acquired immune deficiency syndrome (AIDS) is a viral disease caused by human immunodeficiency virus (HIV) that is usually found in body fluids like blood, semen, vagina fluid, and breast milk of infected persons (Arinola and Adekunjo, 2012). The virus can be transferred from one infected person to another, mostly through sexual intercourse and sharing of unsterilized instruments like blades, knives, and syringes which had once been used by infected persons (Olaleye, 2003). Since it was first discovered in the early 1980s, scientists have been struggling to find a cure for the disease without success. The best that have been achieved so far is management of the infection to prolong the lives of infected persons. This management entails regular intake of anti-retroviral

drugs to boost the immunity of infected persons against other diseases referred to as opportunistic infections. According to Arinola and Adekunjo (2012), HIV/AIDS is an extraordinary kind of crisis; it is both an emergency and a long-term development issue. Tumer and Unal (2000), as quoted by Arinola and Adekunjo (2012), assert that HIV/AIDS is one of the most complex health problems of the 21st century. Despite increased funding, political commitments and progress in expanding access to HIV treatment, the AIDS epidemic continues to outpace every global response. It is estimated that about 24.7 million people are living with HIV/AIDS in sub Saharan Africa. It is among the leading causes of death in this region (Arinola and Adekunjo, 2012).

The mode of transmission of the disease makes it all the more dangerous. It is transmitted through sexual intercourse with infected people, sharing sharp objects, blood transfusion, etc., thereby impacting seriously on our mode of social interactions. People have to adjust their lifestyles and the manner of their social interactions. As a result many issues are involved in the control of the infection. It is a well known fact that awareness of these issues, especially among the most vulnerable group in the populace which is the youth, can enhance efforts to control the spread of the virus.

The issue of HIV/AIDS has become the concern of governments across the world. As the spread of the disease does not recognize national boundaries, all countries of the world are involved in bringing the scourge under control. Funds that would otherwise have been spent on control and treatment of other common diseases like malaria as in the case of sub-Sahara African countries and childhood killer diseases are now being over stretched to include the control of HIV/AIDS. This has brought considerable pressure on the finances of most African countries. Nigeria's effort at bringing the spread of the virus under control in the country is coordinated by National Action Committee on AIDS (NACA). At the state level, State Action Committee on AIDS (SACA) was formed to complement the activities of NACA at the Federal level. When the epidemic was first reported in Nigeria, the government did not respond with decisive action until 1999 when a democratic government came into power. NACA was formed by the government in 2001 and in spite of the efforts of the agency, about 1,000 fresh cases of HIV infections, mostly among the youths, are recorded everyday in Nigeria (NACA, 2010). As a result many research works tend to focus on young people. Ruma (2009) carried out a cross sectional study to determine the knowledge and awareness of HIV/AIDS among senior secondary schools in some parts of the north. The study revealed that the majority knows what HIV/AIDS is and they are aware that the disease has no cure. Also a high percentage knows that the disease can kill. Fawole et al. (2011) examined the level of awareness of HIV/AIDS and sexual behavior of tertiary institution students and found that in spite of high level of awareness among the students, they were still found to engage in risky sexual practices. Momoh et al. (2006) examined the issue of school age girls' awareness in Nigeria. They found that female undergraduates show a moderate level of awareness but among divorced students, as a sub-variable of marital status, there was poor awareness of HIV/AIDS issues.

HIV/AIDS AND YOUNG PEOPLE

Young people are the most affected group in any society. United Nations AIDS Programme (UNAIDS) has estimated that every minute of every day, five young women and

men become newly infected with HIV. Worldwide, nearly half of all new HIV infections today are in young people aged 10 to 25 years, and in the worst affected countries, the proportion is even greater, exceeding 60% in some places. In 1999, UNAIDS estimated that one third of all infected individuals were youths, ages 15 to 24, and half of all new infections occur in youths of the same age (UNAIDS, 1999). They also estimated that about half of the world's total new adolescent HIV infections occur in sub-Saharan Africa (UNAIDS, 1999) and in fact nearly 70% of people living with HIV/AIDS live in sub-Saharan Africa, and over 80% of AIDS deaths have occurred there. HIV/AIDS has had a devastating effect on African youths who often lack access to sexual health information and services.

Higher institutions of learning have a good concentration of young people who interact on a daily basis. They are a very susceptible environment for transmission of the virus. It is therefore, very important that students in higher institutions of learning have the right attitude towards issues of HIV/AIDS. A good attitude can greatly reduce the spread among the students and contribute to the control effort nationally. Awareness programs are not in short supply in Nigerian universities. They come in the form of seminars, symposium, bills, leaflets and one-on-one discussion (Onyene et al., 2010). In spite of various campaigns about HIV/AIDS, there is a conception that the prevalence rate of the scourge is high among the students in tertiary institutions (Fawole et al., 2011). Among researchers who have questioned the effectiveness of the various awareness programmes are Ibe (2005) and Magnus and Gbakeji (2009). On the other hand, Onyene et al. (2010), Omoregie (2002), and Adedimeji (2003), are of the opinion that the problem might not be awareness as there is usually high level of awareness among the students. The problem might be attitudinal. Many of them simply do not care or are indifferent to the risk associated with unsafe sexual practices.

VOLUNTARY COUNSELING AND TESTING (VCT)

One of the ways by which young people can be more responsive to the issues of HIV is through voluntary counseling and testing. By voluntarily submitting themselves for counseling and testing, the point is being made that the message of HIV awareness is getting across to them. VCT is an opportunity for people to receive counseling and at the same time, be tested for the virus. This process prepares people for the outcome of the test, whether positive or negative. For people who are negative, it encourages them to adopt preventive measures while for those who tested positive, VCT will encourage them to show a sense of responsibility in society by not spreading the virus to other people. It will also allow them to make informed decisions concerning

marriage, child-bearing, etc. According to USAID Project Search (Task Order No. 2), VCT allows individuals to learn their HIV status through pre-and post-test counseling and an HIV test. VCT is client-initiated, as opposed to provider-initiated testing and counseling (PITC) when health care providers initiate discussion of HIV testing with clients who are seeking health care for other reasons.

By combining personalized counseling with knowledge of one's HIV status, VCT is designed to motivate people to change their behaviors to prevent the acquisition and transmission of HIV, reduce anxiety over possible infections, facilitate safe disclosure of infection status and future planning, and improve access to HIV prevention and treatment services.

According to UNFPA, some countries have introduced mandatory testing for certain categories of individuals which includes prospective students applying to enter university (Ecuador), new military recruits (China), first time antenatal attendants, refugees, those in institutionalized care like orphanages, detention centers, prisons, etc. UNFPA identified a common feature of mandatory testing as the lack of counseling and supportive services offered after testing. The concept of mandatory testing should not be encouraged as it does not ensure that individuals and couples are provided with all the information necessary to make an informed decision as to whether or not to test, and the enabling environment to cope with the outcome/results of the test. It does not also ensure that people are voluntarily complying with awareness and preventive measures being promoted by society.

Nigeria does not have a policy of mandatory testing and counseling as this will be considered to violate people's right to self-determination or freedom of choice. However, patronage at VCT centers is not common. People do not voluntarily go for counseling and testing but they may submit themselves for testing if required as part of service delivery by a health service provider. This is as a result of stigmatization suffered by carriers of HIV in the society. Unless it is absolutely necessary, people will not go for test. Majority of tests carried out in Nigeria will fall into the category of PITC. This work examines, among other things, patronage of VCTC by students and their attitude towards the services. The work also examines sentiments, particularly religious sentiments, and how it affects their attitudes towards VCT. It also looked at such habits as smoking, condom use and the practice of safe sex.

METHOD OF DATA COLLECTION

Questionnaires were used to collect data. Four institutions were sampled and data were obtained from 50 randomly selected students from each of the four institutions, making a total of 200 respondents. Where a respondent declined to answer the questions, the researcher randomly interviewed another student to make up the number. The questions provided options for the students to

choose from while in some cases, the questions were left open for answers to be provided by the respondents. The questions were straight to the point and did not request respondents to give unnecessary information about themselves. This helped to build confidence in the respondents and they were able to answer the questions as freely as they could.

RESULTS AND DISCUSSION

Statistical Package for Social Sciences (SPSS) was used to analyze the data. Preliminary analysis shows that 85% of the respondents were below the age of 30 years and over 30% were in the age bracket of 20 to 24 years. About 46% of the sampled students were single, 30.5% were married, 13% were co-habiting and 10.5 were divorced. The age group 20 to 24 years has the highest percentage of married students which stands at 43%, while 47% were single and 6% were co-habiting. Only 3% were divorced. Next to this age group in terms of the number of married students is the 'above 30 years' age group which has 34.5% married students. About 19.2% of them were single, 10.3% cohabiting and 37.7% divorced. The age group '15 to 19 years' has the highest percentage of single students which stands at 77.4% and second highest percentage of co-habiting students (16.1%) (Table 1).

The data also revealed that 58.7% of singles have unprotected sex, 96.2% of those cohabiting have unprotected sex and 95.2% of divorced students also have unprotected sex. The percentage of those who use protected (safe) sex was even higher (9.8%) among married students than those cohabiting (6.38%), and those divorced (4.83%) students. This is worrisome because these two groups fall into the groups that are more likely to have multiple sexual partners (Table 2).

Concerning students that have undergone HIV/AIDS test, divorced students had the highest percentage of 81%, followed by co-habiting students with a percentage of 76.9%. Married students had a percentage of 68% and singles students had 46.7%. Majority of single students have never had an HIV/AIDS test (Table 3).

The percentages of the students that have visited the VCT centre stood at 31% for single students, 18.5% for married students, 10% for co-habiting students and 6% for divorced students.

Investigation was made as to the impact of religious sentiment on VCT, unprotected sex and HIV/AIDS test. A chi-square test was carried out and it was found that the null hypothesis of independence between religion and each of the control measures were rejected for HIV/AIDS test with a probability of 0.015, not rejected for VCTC with a probability of 0.078 and rejected for unprotected sex with a probability of 0.002. This means that decision to visit a VCT centre is not influence by religion. Having HIV/AIDS test and practice of safe sex are influenced by religion sentiments. Smoking habit was also examined to see how it relates to the control measures for HIV/AIDS.

Table 1. Distribution of respondents by age and marital status.

Age	Marital status				Total	
	Single	Married	Cohabiting	Divorce		
15-19	Count	24	2	5	0	31
	% within age	77.4	6.5	16.1	0.0	100.0
	% within marital status	26.1	3.3	19.2	0.0	15.5
	% of total	12.0	1.0	2.5	0.0	15.5
20-24	Count	39	36	5	3	83
	% within age	47.0	43.4	6.0	3.6	100.0
	% within marital status	42.4	59.0	19.2	14.3	41.5
	% of total	19.5	18.0	2.5	1.5	41.5
25-29	Count	24	13	13	7	57
	% within age	42.1	22.8	22.8	12.3	100.0
	% within marital status	26.1	21.3	50.0	33.3	28.5
	% of total	12.0	6.5	6.5	3.5	28.5
30-Above	Count	5	10	3	11	29
	% within age	17.2	34.5	10.3	37.9	100.0
	% within marital status	5.4	16.4	11.5	52.4	14.5
	% of total	2.5	5.0	1.5	5.5	14.5
Total	Count	92	61	26	21	200
	% within age	46.0	30.5	13.0	10.5	100.0
	% within marital status	100.0	100.0	100.0	100.0	100.0
	% of total	46.0	30.5	13.0	10.5	100.0

Table 2. Students' marital status and practice of safe sex.

Marital status		Unprotected sex		Total
		Yes	No	
Single	Count	54	38	92
	% within marital status	58.7	41.3	100.0
	% within unprotected sex	35.1	82.6	46.0
Married	Count	55	6	61
	% within marital status	90.2	9.8	100.0
	% within unprotected sex	35.7	13.0	30.5
Cohabiting	Count	25	1	26
	% within marital status	96.2	3.8	100.0
	% within unprotected sex	16.2	2.2	13.0
Divorce	Count	20	1	21
	% within marital status	95.2	4.8	100.0
	% within unprotected sex	13.0	2.2	10.5
Total	Count	154	46	200
	% within marital status	77.0	23.0	100.0
	% within unprotected sex	100.0	100.0	100.0

Table 3. Distribution of HIV test by marital status.

Marital status		HIV test		Total
		Yes	No	
Single	Count	43	49	92
	% within marital status	46.7	53.3	100.0
	% of Total	21.5	24.5	46.0
Married	Count	42	19	61
	% within marital status	68.9	31.1	100.0
	% of Total	21.0	9.5	30.5
Cohabiting	Count	20	6	26
	% within marital status	76.9	23.1	100.0
	% of Total	10.0	3.0	13.0
Divorce	Count	17	4	21
	% within marital status	81.0	19.0	100.0
	% of Total	8.5	2.0	10.5
Total	Count	122	78	200
	% within marital status	61.0	39.0	100.0
	% of Total	61.0	39.0	100.0

It was found that the hypothesis of independence is rejected at .007 level of significant for unprotected sex which means the practice of safe sex can be influenced by students who have a habit, particularly smoking habit. The hypothesis of independence between smoking habit and HIV test is upheld at 0.158 level of significance. It can therefore be said that smoking habit does not affect a student's decision to have HIV test. Also the hypothesis of independence between smoking habits and VCT is upheld at 0.402 level of significance, which means smoking habit does not affect student's decision to visit a VCT centre. Other habits like drinking and taking hard drugs were not examined.

Conclusion

Not many researches have been done on the impact of the promotion of behavioral change interventions aimed at reducing the spread of the virus. Such behavioral changes include abstinence, delaying the onset of first sexual intercourse, use of condoms, reducing the number of sexual partners and so on (Michielsen 2012).

Additionally, they aim to increase knowledge, change attitudes, improve access to services and to reduce stigma or address other mediators as self-esteem and self efficacy. But it is generally observed that the interventions have had little or no effect on people's behavior in sub-Sahara Africa, especially among young people. Michielsen (2012) found that interventions have had little

or no positive effects on sexual behavior, and 'condom use at last sex' only increased marginally among males but remained at a low level.

The results of this analysis tend to point in this direction. Level of safe sex is low, particularly among single students. Only about 41% practice safe sex in spite of the measures being used by various government agencies, non-governmental agencies and other concerned organizations to educate the youths about the need for safe sex. Majority of the students do not go for voluntary HIV test. The percentage of those that have VCT is as low as 31% among the singles students.

Habits and sentiments also play some roles in the attitude of students towards these intervention measures. Smoking habit influences safe-sex practice. Those who smoke are more likely to have unprotected sex. Religion sentiment among the students is strong and has influence on student's decision to have HIV test.

REFERENCES

- Adedimeji A (2003). Perception of HIV/AIDS Infection and Condom use Among Undergraduates in Nigerian Universities. Department of Sociology, University of Ibadan, Ibadan Nigeria.
- Arinola AA, Adekunju OA (2012). Analysis of HIV/AIDS Information Awareness and Effectiveness Among Artisans in Ogbomoso, Oyo State, Nigeria. Library Philosophy and Practice.
- Fawole AO, Ogunkan DV, Adegoke GS (2011). Sexual Behavior and perception of HIV/AIDS in Nigerian Tertiary Institutions: University of Ilorin a Case Study. *Global J. Human Social Sci.* 11:1
- Ibe SN (2005). HIV/AIDS Awareness Study of Fresh Students in Tertiary Institutions in Rivers State, Nigeria. *J. Appl. Sci. Environ.* 9:1

- Magnus OO, Gbakeji JO (2009). Analysis of Spatial Awareness of HIV/AIDS amongst Students of Tertiary Institutions in Edo State, Nigeria. *J. Ethno-Med.* 3:2.
- Michielsen K (2012). HIV Prevention for Young People in Sub-Saharan Africa: Effectiveness of Interventions and Areas of Improvement, Evidence from Rwanda. *Africa Focus* 25(2):132-146.
- Momoh SO, Moses AI, Ugomoh MM (2006). Women and the HIV/AIDS Epidemic: The Issue of School Age Girls' Awareness in Nigeria. *J. Int. Women's Stud.* 8(1):212-218.
- NACA-REACH International Symposium (2010). Emerging Strategies to Combat HIV/AIDS in Nigeria: Enhancing Prevention and HIV Counseling and Testing. Abuja, Nigeria.
- Olaleye RS (2003). Level of HIV/AIDS Awareness Among Rural Farmers and its Implication for Food Security in Ondo State, Nigeria. *J Agric. Soc. Res.* 3(2):1-11.
- Omeregbe GO (2002). Sexual Behavior of Tertiary Institution Students Using the PSI behavioral Change Framework. Society for Family Health, Abuja, Nigeria.
- Onyene V, Uzoka N, Ikonta N, Bakare TV (2010). Tertiary Institution Learners' HIV/AIDS Sensitization Tool(s) Receptability: Implication for Sustainable Democracy in Nigeria. *J. AIDS HIV Res.* 2(4):79-87.
- Tumer A, Unal S (2000). Epidemiology of HIV infection in the World and Turkey. In: Unal S (ed.), *AIDS: Modern Medical Seminar*, Ankara, Turkey.
- UNAIDS (1999). Five years since ICPD. UNAIDS Information Centre, Geneva, Switzerland.
- Ruma MM (2009). Knowledge and Awareness of HIV/AIDS among some Senior Secondary School Students in Katsina, Nigeria. *Bayero J. Pure Appl. Sci.* 2(2):121-126.