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HIV VOLUNTARY COUNSELLING AND TESTING FOR YOUNG PEOPLE: THE ANTIDOTE FOR A HEALTHY AND POSITIVE LIVING IN NIGERIA.

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Abstract

The study investigated the disposition of young people towards HIV voluntary counselling and testing in Nigeria. The sample consisted of six hundred and five young people ($n=605$, mean = 19.5 years). To accomplish this research purpose, three research questions and two hypotheses were formulated. The research adopted a descriptive survey method and the instrument for data collection was a 55-item questionnaire titled Questionnaire on HIV VCT (QHVT). Descriptive and inferential statistics at 0.05 alpha level were used to analyze the data. The findings of this study include that young people have very poor knowledge of VCT sites, that there is a significant difference in the disposition to HIV VCT between respondents who have experienced sexual intercourse and those who have not ($t = -23.36$, $df = 603$; $p < 0.05$). Another finding is that sex and age would significantly predict attitude of young people towards HIV VCT ($R = 0.642$; $R^2 = 0.412$; $F_{(3, 601)} = 140.147$; $p < 0.05$). Based on the findings, it was recommended that young people should be sufficiently enlightened and counselled on the imperative of voluntary HIV counselling and testing

Key words: HIV Testing and Prevention, young people, healthy living, knowledge of HIV/AIDS and VCT sites.

Introduction

The Human Immuno-Deficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) have become a major health issue in

Nigeria. HIV/AIDS cases have been reported in all regions of the world, but most people living with HIV/AIDS (95%) reside in the low- and middle-income countries, where most new HIV infections and AIDS-related deaths

occur (UNAIDS, 2006). The epidemic is considered a threat to the economic well-being, social, and political stability of many nations, it is one of the greatest humanitarian and development challenges facing the global community including Nigeria (Osagbemi, Joseph, Adepetu, Nyong & Jegede, 2007; United Nations, 2005; Lloyd, 2004; MAP Report, 2004 & Kapungwe, 2003). However, sub-Saharan Africa with only 10% of the world's population has over two-thirds of the population living with HIV-22.5m people in 2007 (UNAIDS 2007). It is estimated that about 3.8 million people are living with HIV in Nigeria, which implies that 1 in 7 Africans living with HIV is a Nigerian. Young people constitute an important segment of the world's total population and among the new cases of HIV; 50-60% are young people. There is no gainsaying the fact that HIV is a generalized epidemic affecting all segments of the society especially young people (HDR, 2004; Simbayi, Shisana, Chauveau & Ramlagan, 2003; UNAIDS, 2007 & WHO, 2007). It has been documented that HIV is ravaging the lives of the younger population due to the features of this stage like sexual experimentation, invulnerability and a general belief of invincibility (Adekeye, 2005; Adegoke, 2004).

Since at present, there is no cure for HIV and AIDS, the best option is to prevent its transmission. The rate of

transmission of HIV tends to increase considerably yearly, except for some noticeable and appreciable changes in 2007 (UNAIDS 2008). To many individuals, HIV/AIDS is still like a mirage, and to prevent the spread of HIV starts with a first step which is the need for information about the virus, how it can be contracted and its deadly consequences. This can be achieved through HIV counselling and testing, which is voluntary in nature. HIV voluntary counselling and testing (HIV VCT) has been shown to have a role in both prevention and care for people with HIV infection as an entry point to care and support. VCT helps in behaviour change and as noted by Papalia, Olds, & Feldman (2001), good health is not just a matter of luck. People can seek healthy and positive living by pursuing some activities and reframing from others.

Voluntary Counselling and Testing (VCT) according to Human Development Report (2004: 84) is "the process that enables an individual to undergo a change in behaviour in order to make an informed choice about being tested for HIV." HIV VCT assist an individual to undergo counselling which enables him/her to make informed decision/choice about being tested for HIV. The decision to undertake voluntary counselling and testing must entirely be the choice of the individual and he/she must be

assured that the process will be confidential (Kalichman & Simbayi, 2003 and UNICEF, UNAIDS & WHO 2002, UNAIDS, 2007). Thus, VCT enables confidential HIV testing and the voluntary nature of VCT is one of its underlying principles (IPPF & UNFPA, 2004).

Due to stigmatization and discrimination, UNAIDS (2006) stipulates that testing should be voluntary and confidential. People who have chosen to be counselled and then have gone on to have an HIV test have, in some studies registered some behaviour change that contributed to lower rates of HIV spread (Paltiel, Weinstein & Kimmel, 2005 & Reiss, Kim & Downing 2001). In addition, the availability of VCT services is thought to be a factor in reducing stigma-surrounding HIV and in encouraging community support and care for those affected. In a study by Samet, Winter, Grant, and Hingson (1997), of the 567 adolescents surveyed who had sexual intercourse within the past year, 127 (22%) had received HIV testing, with 54 (10%) stating that this testing was for personal reasons. A "great deal" or "some" worry about getting HIV/acquired immunodeficiency syndrome (AIDS) was expressed by 51%, and 56% felt that it was at least a little likely that they will get AIDS. Misconceptions were common about aspects of HIV testing: 35% did not believe or did not know

that the HIV test results were kept in confidence, 19% thought that AIDS testers informed partners if the results were positive, and 30% did not think that the HIV test was very accurate. Although 92% (452/490) had seen a physician in the past year, only 30% had ever discussed HIV/AIDS with a doctor.

UNFPA (2005) reports that different studies have shown the effects of VCT, such as a decrease in unprotected sexual intercourse, a reduction in multiple partners, an increase in condom use, and more clients choosing abstinence. Although VCT is a relatively costly activity, it is seen to be a cost-effective intervention for sexual behavioural change. In a study by Youth Net (2002), many young people desire HIV VCT services, but they complained that HIV VCT services are limited and involve many questions. Lloyd (2004) note that since the mid 1980s, HIV testing has contributed significantly to understanding HIV and its distribution and to determining serostatus of individuals.

To achieve the objectives of this study, three research questions and two hypotheses were raised. The research questions are: 1. Do young people understand what HIV connotes, means of transmission, prevention and the sources of HIV information? 2. What are the attitudes of young people towards voluntary and confidential HIV counselling and testing? 3. Do the

participants engage in sexual intercourse and do they possess adequate knowledge of HIV VCT centres in their communities? The research hypotheses states that i. there will be a significant difference in the disposition to HIV VCT between respondents who have engaged in sex in the last six months and those who have not, and ii. that there is a significant combined contribution of knowledge of HIV/AIDS, sex and age in the prediction of attitude of young people towards HIV voluntary counselling and testing.

Research Design

The research design adopted for this study is the descriptive survey method. This method is preferred because it helps to collect data from large numbers of participants on a particular topic, and it may involve self-report questionnaires or highly structured interviews (McQueen & Knussen, 2006).

Population and Sampling Techniques

The target population for the study is all young persons between 15 and 24 years in Nigeria. It is estimated that half of the 33.2 million people in the world who are infected with HIV were infected between the ages of 15 and 24 years (UNAIDS, 2007). Multistage and purposive samplings were employed in selecting the sampled geo-political

region, states and towns. The Southwest region was purposively chosen due to easy accessibility. The Southwest region consists of six states and through a multistage sampling technique, three states and six (6) local governments were chosen. The first stage of the multistage random sampling involves randomly selecting the three participating states and this was done through a dip hat method. Oyo, Lagos and Ogun States were thus picked out of the six states constituting South-West, Nigeria. In the second stage, another random sampling was conducted to select two (2) local government areas (LGA's) in all the three states bringing the number of LGA's to six (6). The researcher stopped at the second stage because the six local government areas (LGA's) were deemed sufficient for the conduct of the study. The sample for the study consists of six hundred and five (605) respondents drawn from the three states. The category of young people that were considered in this study includes students (303), traders (180) and artisans (122).

Instrumentation:

A self-developed questionnaire titled Questionnaire on HIV VCT (QHVCT) was used to obtain relevant data for this study. Sixty-six (66) items were initially generated through critical review of literature, views of colleagues and my students. After a preliminary study

including expert opinions, the items were reduced to fifty-nine (59), and after the pilot study was conducted, some restructuring were made to the scale thus reducing the number of items to fifty-five (55). Section A of the QHVCT deals with the demographic details of the respondents such as sex, age, had engaged in sexual intercourse or not, state of residence and educational level, while Section B contains the scales to measure the variables of the study. The following variables were measured: General knowledge of HIV/AIDS, level of sexual engagement, knowledge of HIV VCT sites and services offered and attitude to HIV VCT.

Psychometric Properties of the QHVCT

The QHVCT has a convergent validity with the Voluntary Scale of **Hamill, Copas and Murphy** (2006), Knowledge, Attitudes, Beliefs and Practices (KABP) of Ingham and Stone

(2006), and A Questionnaire Study by Tan, Pan, Zhou, Wang, and Xie (2007). The QHVCT was subjected to a test-retest reliability measure. The Pearson's r yielded 0.73 while the internal consistency reliability of the two administrations using the Average inter-item correlation yielded a reliability estimate of 0.71 and 0.74 respectively. With the validity and reliability ascertained, the instrument was considered adequate for testing purposes.

Procedure for Data Collection.

The questionnaire forms were administered to the respondents with the aid of three trained research assistants. The questionnaires were collected immediately the respondents were through with them.

Methods of Data Analysis

The data were analyzed using both descriptive and inferential statistical methods, such as frequency counts and percentages, t-test statistic and regression analysis.

Results

Table 1: General Knowledge of HIV of Young People and Sexual Experimentation

Knowledge of HIV	Frequency	Percentage
HIV causes AIDS	577	95
HIV is a contagious disease	389	64
HIV is presently incurable	509	84
Transmission of HIV HIV/AIDS is transmitted through		
Sexual intercourse without condoms	591	98
Blood from an HIV infected person	332	55
Sharing of needles among drug users	344	57
Prevention of HIV		
Abstaining from sex	457	76
Being faithful to ones partner	586	97
Using condom during sex	602	99

Sources of HIV information

Sources	%	Sources	%	Sources	%
Television	87	Radio	92	Newspaper	21
Magazine	28	Parents	55	Friends	33
Church/Mosque	19	Nurses	43	Doctors	21
Family members	77	Posters/Billboard	65	Teachers	45

Table 1 shows the general knowledge of HIV/AIDS measured on four levels viz knowledge, routes of transmission, how to prevent the transmission of HIV/AIDS and respondents' sources of HIV information. Data indicates that most young people have good knowledge of HIV/AIDS (HIV causes AIDS, 95% and HIV is presently incurable 84%). Ninety-eight percent (98%) correctly identified sexual intercourse without condoms as one of the routes of transmitting HIV, while the response to HIV prevention shows that young people have the

capacity to stay away from HIV infection. Ninety-nine percent (99%) correctly identified using condom during sex to prevent HIV while 97% and 76% identified being faithful to ones partner and abstaining from sex to prevent HIV respectively. Five hundred and fifty seven (557 or 92%) indicated radio as their source of HIV information while 526 (87%) indicated television. Seventy seven percent (77%) got their HIV information from family members. Others are posters/billboards (65%), nurses (43%) and doctors (21%).

Table 2: Attitudes of Young People towards HIV Voluntary and Confidential Counselling and Testing

Statements n=605	N	Rank
Knowing my HIV status is just necessary	246	10 th
Knowing my HIV status will be beneficial to me and others	321	9 th
To know if I am positive so that I do not transmit to others	355	8 th
I do not engage in sexually risky behaviours	369	7 th
I am not just interested for now	387	5 th
I am not sure about the confidentiality of my test result	472	1 st
Did not want to think about HIV or about being HIV positive	451	2 nd
Did not know where to get tested	408	3 rd
Fear of treatment if HIV positive	388	5 th
Fear of imminent death if HIV positive	394	4 th

Responses from Table 2 reveal that young people have a mix of positive and negative attitudes towards HIV Voluntary and Confidential Counselling and Testing. The ranking show that the respondents were not sure about the

confidentiality of HIV test result and did not want to think about HIV or about being HIV positive. The ranking also indicates that they did not know where to get tested for HIV/AIDS.

Table 3: Level of Sexual Engagement and Knowledge of HIV VCT Centres in Communities

Level of Sexual Engagement	N	%
Have had sexual intercourse	154	25
No sexual intercourse	451	75
HIV VCT Centres		
	N	%
Government Hospitals	224	37
Private Hospitals	186	31
Clinics	112	19
Counselling centres	84	14
Drug shop/Pharmacy	19	3

Table 3 shows that 154 or 25% of respondents have engaged in some form of sexual relationship while 451 or 75% have not had sexual intercourse. Young people have poor knowledge of HIV VCT centres, 37% and 31% of respondents are aware that government and private hospitals provide HIV VCT services respectively. Nineteen percent (19%) indicated

clinics and 14% counselling centres. Nineteen respondents (3%) reported that drug shop/pharmacy provides HIV VCT services.

Hypothesis 1: There will be a significant difference in the disposition to HIV VCT between respondents who have engaged in sex in the last six months and those who have not.

Table 4: Summary of t-test showing disposition towards HIV VCT

Group	N	Mean	S.D	df	t cal.	p
Had intercourse in last six months	154	26.35	32.24			
Have not engaged in sex	451	2.38	2.39	603	26.36	.000

Table 4 shows that there is a significant difference in the disposition to HIV VCT between respondents who have experienced sexual intercourse and those who have not ($t = 23.36, df = 603; p < 0.05$). Hypothesis 1 is therefore sustained.

Hypothesis 2: There is a significant combined contribution of knowledge of HIV/AIDS, sex and age in the prediction

of attitude of young people towards HIV voluntary counselling and testing.

Table 5: Model Summary of Regression Analysis

R= 0.642

R²= 0.412

Adj R= 0.409

Std E= 2.698

	SS	DF	MS	F	P
Regression	3062.349	3	1020.783	140.147	.000
Residual	4377.463	601	7.284		
Total	7439.812	604			

Data in Table 5 reveals that sex and age would significantly predict attitude of young people towards HIV VCT ($R=0.642$; $R^2=0.412$; $F_{(3, 601)}=140.147$;

$p < 0.05$). When combined, both sex and age predicted about 41% of the variation in attitude towards HIV VCT.

Table 6: Relative Contributions of Gender, Age and Knowledge to HIV VCT

Model	Unstandardized Coefficient		Standardized Coefficient Beta	t	p
	B	Std Error			
Constant	19.989	1.105		18.083	.000
Sex	4.114	.243	.568	16.958	.000
Age	1.505	.295	.171	5.105	.000
Knowledge	4.681E02	.030	.050	1.562	.119

Table 6 shows the relative contributions of sex, age and knowledge to predicting attitude towards HIV VCT. The summary table reveals that of all the three predictor variables, knowledge was not a strong predictor of attitude of young people towards HIV VCT. With Knowledge ($\hat{\alpha} = 0.050$; $t = 1.562$ $p > 0.05$), Sex ($\hat{\alpha} = 0.568$; $t = 18.083$ $p < 0.05$), and Age ($\hat{\alpha} = 0.171$; $t = 5.105$ $p < 0.05$). In effect, sex is the best predictor of attitude towards HIV voluntary counselling and testing. The hypothesis which stated that there is a significant combined contribution of knowledge of HIV/AIDS, sex and age in the prediction of attitude of young people towards HIV voluntary counselling and testing was accepted for sex and age and rejected for knowledge of HIV/AIDS.

Discussion

The finding of this study shows that young people have very poor knowledge of VCT sites and services offered. This finding is in tandem with a study by Delva, Wullaume, Vansteelandt, Claeys, Verstraelen, Broeck and Temmerman (2008). The result of the first hypothesis shows that young people who had engaged in sexual activities were less willing to present for HIV counselling and testing while those who have not engaged in sexual activities were more willing to present themselves for HIV VCT. This suggests that young people who engage in sexual intercourse are aware that it is risky, hence, their reluctance to go for HIV testing regardless of whether it is free or not. Bartlett (2008) notes that sexually active people avoid testing because of anxiety about the possibility of a positive test result. Brian,

Ostermann, Whetten & Kumar (2007) found that high-risk groups want to get tested – but their actions do not match up with their intentions. According to Bartlett (2008), most individuals who are at the highest risk for HIV have not been tested, usually because they do not realize that they are at risk.

The result of hypothesis two shows that knowledge of HIV was not a good predictor of attitude towards testing, rather, the finding revealed that sex and age were good predictors. UNAIDS (2006) notes that 55.2 percent of people within ages 15-24 in Zimbabwe correctly identified ways to prevent HIV, 26.5 percent in Mozambique, 40.5 percent in Kenya and only 19.15 percent in Nigeria. Enosolease & Offor (2004) notes that high knowledge about HIV/AIDS do not necessarily translate to positive disposition towards HIV testing. Further analysis showed that respondents within ages 15-18 and more females were disposed to HIV voluntary counselling when compared to those in the 19-24 age category and male respondents. Reiss, Kim & Downing (2001) notes that gender differences exist regarding reasons for HIV testing. The most significant finding was that women were motivated to test with regard to concerns related to family and significant others in their life more so than men, particularly during pregnancy. Ompad, Strathdee, Kellam,

Latkin, Celentano, Poduska, Ialongo (2002) conducted a multivariate analysis and reported that ever having an HIV test was associated with being female; females were also more likely to report STD symptoms than males and those females were 1.72 times more likely to have been tested for HIV. Adegoke (2003) notes that there is ample evidence to show that the willingness of youths to engage in risk-taking behaviours (sexual activity, dropping out of school, substance use and abuse and violence) is normative. He went further to posit that because risk-taking behaviours are common to youth, culture does not excuse those behaviours nor does knowledge of the behaviour reduce the danger that those behaviours present.

Conclusion

The objectives of this study are within the framework of the aim of sustaining and increasing knowledge of HIV and voluntary counselling and testing among young people. There is still a strong reluctance to access testing amongst much of the population under review, for instance, in a study by UNAIDS (2007), only 18 percent of women and 21 percent of men between the ages of 15 and 24 could correctly identify ways to prevent HIV. In most developing economies, the priority now is to scale up access to HIV VCT especially for young people. More avenues and outlets to increase general

knowledge of HIV need be explored, because knowledge of HIV and one's HIV status can greatly reduce the risk of transmission to others. Increased HIV testing has been shown to be a cost-effective means of protecting health at both the individual and community level (Paltiel, Weinstein, and Kimfrel 2005; Rotheram-Borus, Leibowitz, and Etzel 2006). If young people are sufficiently enlightened and counselled on the imperatives of voluntary HIV counselling and testing, they will of necessity influence their friends and sex partners to seek VCT, thus reducing the influence of sexual networking in the spread of HIV.

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