Research Paper
Impact Factor: 4. 695
Peer Reviewed & Indexed Journal

IJMSRR
E- ISSN - 2349-6746
ISSN -2349-6738

ATTITUDE TOWARD MANDATORY PREMARITAL HIV TESTING AMONG YOUTH IN AZARE TOWN, BAUCHI STATE, NIGERIA

Magaji Bappa Sulaiman* Sule Musa* Mohammed Uba Aliyu*
** Department of Social Studies, Aminu Saleh College of Education, Azare, Bauchi State Nigeria.*

Abstract
Mandatory Premarital HIV Testing (MPHT) is a response to HIV/AIDS. The response, which is gaining popularity in Nigeria, is seen by as a breach of confidentiality and informed consent. This study examined attitudes toward MPHT among youths in Azare, Bauchi State and related ethical issues. The health belief model provided the theoretical framework. Quantitative and qualitative methods were used to analyze the data. Data were collected through a survey using closed and open ended questions on 380 respondents. In-depth-interviews (IDI) were conducted with 8 purposively selected participants. Descriptive statistics, chi-square and content analysis were used to analyze the data. The study found no association between perceived stigmatization and acceptance of MPHT. Despite low utilization of VCT services (12.2%), the MPHT proved acceptable (65.5%). The findings show that majority of the respondents (89.4%) are willing to cancel marriage plan should a partner refuse HIV test. Parental and religious influences are found to play a role in shaping opinions toward the MPHT. Majority of respondents (82.7%) consider the MPHT in harmony with religious teachings. On ethical issues, 64.7% agreed with disclosure of HIV test results when somebody is at risk but under normal circumstance 51.2% prefer confidentiality. The study recommends among others that VCT should be popularised as against Mandatory Premarital HIV Testing. However, where the MPHT prove acceptable public disclosure of test results should be avoided.

Key Words: Mandatory Premarital HIV Testing, Attitude, Ethical Issues, Youth.

Introduction

Since the discovery of the virus in the early 1980s in the United States (U.S.) (Abdullahi, 2009), several studies were carried out on the knowledge of HIV/AIDS and how its spread can effectively be controlled. Governments and their agencies, including Non-Government Organisations (NGOs) and Faith-Based Organisations (FBOs) continue to sponsor researches with a view to come up with various responses aimed against the magnitude of the threats posed by HIV and AIDS. A particular response that has attracted scholarly attention is the mandatory premarital HIV testing (MPHT). The policy which started in 1987 in the states of Louisiana and Illinois in the U. S. is increasingly being adopted by many national and state governments across the world (Turnock and Kelly, 2009; Open Society Institute, 2013). The MPHT refers to the requirement of an HIV test as a prerequisite for entering into marriage.

Some State governments in the country, such as Yobe and Jigawa have passed a statute making premarital HIV test mandatory. In Bauchi State the proceeding is currently in its second reading at the legislature. However, the MPHT is seen by activists as a violation of human rights and a breach of confidentiality and informed consent which may also increase stigmatization (Policy Project, 2004; Rennie and Mupenda, 2008). In line with the foregoing, investigating people's attitudes towards the MPHT will provide the basis for predicting its acceptability or otherwise among the larger population and how the programme will impact on behaviour change.

Statement of the problem

Despite efforts by the Nigerian government to curtail the spread of HIV/AIDS, complemented by United Nations agencies and NGOs, the prevalence of the scourge continues to rise with a prevalence rate as at 2012 standing at 3.4% (NACA, 2014). Reports have shown that, sub-Saharan Africa has the highest rate accounting to 69% of all HIV infections worldwide (WHO, 2013).

Inadequate knowledge of HIV/AIDS, stigmatization, high risk sexual behaviour, cultural and religious factors continue to affect the success of HIV/AIDS interventions (WHO, 2013). Although the United Nations recommends voluntary counselling and testing (VCT) as one of the ways to control the spread of the disease, its utilization in Nigeria, especially among the youth, is very low (Yahaya et al, 2012; National Population Commission, NPC, 2013). Consequently people who refuse to undergo HIV testing remain ignorant of their status and may continue to spread the infection in the community unnoticed. Hence, the MPHT as a new approach surfaced and which could be promising if popularised and accepted. Bauchi is among the states proposing to pass legislation on the MPHT.

However, one major concern is how to reconcile traditional norms of conducting marriages with the MPHT. In Bauchi, like in most Nigerian communities, marriage is a highly regarded social institution that usually attracts wide publicity. Thus,

whenever a couple are about to get married, it becomes known, not only to relatives but to the community as well. Therefore in cases where discordant marriages are disallowed or discouraged, such cancellations may increase stigma towards people living with HIV/AIDS (PLWHA) hence people will be driven away from the premarital tests.

A survey conducted in the State revealed that HIV/AIDS related stigma remain pervasive as traditional practices and religious beliefs have strong influence on peoples' attitudes and behaviours (Bauchi State Agency for the Control of HIV/AIDS, Tuberculosis, Leprosy and Malaria BACATMA, 2009). Therefore in the absence of any empirical study that ascertained a change in peoples' attitude towards HIV/AIDS, as in the case of the study area, the proposed MPHT might equally be confronted with similar obstacle. Based on the foregoing considerations, the MPHT may have serious socio-cultural implications.

This study therefore examined the knowledge of HIV/AIDS among the youth, their individual and collective attitude toward the MPHT as well as the ethical issues relating to the MPHT. The problem under consideration in this study was to examine youths' knowledge of HIV/AIDS and their attitudes toward the MPHT in order to predict its acceptability or otherwise among the larger population.

Justification of the Study

The Mandatory Premarital HIV Testing (MPHT) is one of the recent interventions introduced as response to the HIV/AIDS pandemic in the country. Bauchi is one of the States that are proposing a statute to that effect. This effort further aggravates the debate surrounding the MPHT.

In spite of the above, there has not been an empirical research conducted in the area under study (so far as I know) to assess peoples' knowledge of HIV/AIDS and attitude towards the MPHT. This necessitated the conduct of this research to serve as a pivotal study in predicting the acceptability or otherwise of the MPHT. Azare town was selected as the area of study because it ranked (6th) in the HIV prevalence in the State (BACATMA, 2009) and share similar characteristics with most of the other towns in the State.

The youth were selected as the target population for the study because they constitute the most vulnerable group (Abdullahi, 2009). It was also assumed that the youth represent the highest percentage of unmarried population in the study area who might be most affected by the MPHT if promulgated into law, even though the sample included respondents within this age category who are married. This is because in the northern part of the country young girls tend to marry at an early age (UNFPA, 2014).

It is also expected that the findings of the study will provide an analytical framework for a larger, more detailed study on people's attitudes towards the MPHT in Nigeria and Africa.

Research Design

Research design relates to the general approach adopted in executing a particular study. Therefore this research used a descriptive cross-sectional study design aimed at examining the knowledge of HIV/AIDS among youths in Azare, Bauchi State as well as their attitude towards mandatory premarital HIV testing. The data for the study were collected through both primary and secondary sources. The primary source involved both quantitative and qualitative methods. The quantitative data were elicited through semi-structured questionnaires which were administered on 380 respondents while the qualitative data were collected through In-depth interview (IDI). Probability and Non-probability sampling techniques were adopted for this study. Probability sampling includes cluster and systematic sampling methods while non-probability sampling used was purposive sampling. The population of the study included all persons aged 15-35 years residing in Azare at the time the research was conducted. The quantitative data was analysed via descriptive and inferential statistical tools; measures of central tendencies and Chi-square using the SPSS software. The qualitative data were analysed through content analysis and reporting of verbatim quotations.

Study Population

The population of the town is estimated at 137,573 (NPoC Bauchi, 2014). The target population in this study comprises of all youths between the ages of 15-35 years in Azare metropolis. According to the Federal Republic of Nigeria (2001) National Youth Policy, one out of every three Nigerians falls within the ages 15-34 years. Therefore, going by this proportion, our study population was estimated at 45,858 youths constituting one-third of the total population of the study area. These included males and females, married or unmarried, who were resident in the study area at the time of conducting the research. The findings from the study provided the necessary information upon which inferences were made.

Sample Size and Sampling Technique

A sample size of 380 respondents was selected out of an estimated population of 45,858 youth in accordance with sample size calculator (Raosoft, 2004) at 95% confidence level. This sample was used to elicit quantitative data. In selecting the subjects, cluster and systematic sampling techniques were used. The three districts in the study area served as the clusters and these are Azare, Nassarawa and Madangala. The three districts have a total of sixty-six (66) communities (Bauchi State Gazette, 2011). Azare district has twenty-five (25), Nassarawa district has thirty-one (31), and Madangala district has ten (10).

The selection was based on proportion hence one hundred and forty-four (144) were selected from Azare district, one hundred and seventy-eight (178) from Nassarawa district, and fifty-eight (58) respondents were selected from Madangala district respectively. There was also a sampling frame for the sixty-six (66) communities from where the sample distribution was drawn. A systematic sample with a random start was used to select the first sample. The subsequent selection was then based on the nth number with an interval of 4. Therefore a total of sixteen (16) communities were finally sampled with the distribution 6:8:2 respectively. The sample size was then drawn at random according to the proportion. This was to ensure that all the study elements were accorded equal chance of being selected. The total sample size for the quantitative data was exactly three hundred and eighty (380) respondents.

Another sample consisting eight (8) interviewees was then purposively selected from where the qualitative data were obtained which were also analyzed and presented with the quantitative findings. The selection took cognisance of some variables such as sex, marital status, religious affiliation, ethnic group and level of education.

1. **Quantitative Method**
   The Semi-Structured questionnaire contained forty-five (45) close-ended items and seven (7) open-ended items and required no personal identification of the respondents. The questionnaire was designed in line with the objectives of the study and divided into five sections. This includes demographic attributes of respondents such as sex, marital status, religious affiliation, level of education, ethnic background, occupation, income etc, respondents' knowledge on HIV/AIDS, attitudes of respondents towards the MPHT, factors that influence youth attitude towards the MPHT and some ethical issues relating to the MPHT. Three hundred and eighty (380) questionnaires were self-administered by the researcher and trained assistants in accordance with the sample distribution.
2. **Qualitative Method**
   In-depth interview (IDI) guide was used to obtain qualitative data to support the quantitative findings. A flexible interview guide with open-ended questions was designed to elicit detail information from purposively selected interviewees. This included eight (8) participants selected from the study population. The selection took cognisance of some variables which include marital status, sex, ethnic group and religion as displayed in table 3.6.1. The researcher used an audio recorder to record all the conversations to complement the note taking. The recordings were then transcribed and compared with the notes. Both questionnaire and interview guide were translated into Hausa language, which is the local language, before the administration.

Quantitative Data Analysis

The data generated were analysed using both the descriptive and inferential statistics. The responses elicited were meant to address each of the specific objectives as appropriate. Demographic information was analysed using descriptive statistics. Objective 1 was meant to investigate the relationship between knowledge of HIV/AIDS among the youth in Azare and resistance to MPHT. In this respect frequency tabulation and chi-square were used in determining the relationship between knowledge of HIV/AIDS and resistance to MPHT. Objective 3 aimed at examining the association between stigmatization and youths' acceptance of MPHT in Azare town. In order to test the perceived association between stigmatization and acceptance of the MPHT, the data were also subjected to chi-square test.

Objectives 4 and 5 were meant to investigate the factors that influence attitudes of youths in Azare towards the MPHT, as well as examine the ethical issues relating to the MPHT respectively. The data generated in this respect were analyzed using the frequency tabulation and percentages as illustrated in tables. The analyses were done using the Statistical Package for Social Sciences (SPSS Version 20) software.

Qualitative Data Analysis

The recorded qualitative data was replayed and compared with the notes before the final transcription. Transcription involves a system of notation and the product in the form of a transcript (Kowal and O'Connell, 2004). Data obtained during the interviews were transcribed and analyzed thematically. These were used to complement the quantitative data which involved verbatim quotations of the respondents.

Ethical Considerations
Before the commencement of the study, verbal informed consent of the respondents was obtained, as they were equally accorded the right to opt out when they desire. Confidentiality was also assured and anonymity guaranteed. No identifiers were required. Traditional norms of the community such as seeking the consent of husbands before interviewing the wives were equally respected and adhered to in the conduct of the research. Invariably the sample included married females in purdah who, by tradition, will not entertain male strangers. Hence female research assistants were employed to administer the questionnaire in such situations. Similarly, during the conduct of the In-depth-interview (IDI), respondents' consent to use a recorder was sought before the commencement of the interview. Access to the records was restricted exclusively to the researcher. In line with academic ethics, all materials cited in this work were duly acknowledged and displayed in the reference.

Table 4.4.1: Respondents' Acceptance/Resistance to MPHT

Question	Variable	Frequency	Percentage
Implementation of premarital HIV test	Mandatory	249	65.5
	Voluntary	127	33.4
	Undecided	4	1.0
	Total	**380**	**100**
Premarital HIV test compulsory by Government	In support	304	88.8
	Indifferent	15	4.3
	In oppose	23	6.7
	Total	**342**	**100.0**

The questions are straight forward and the response chosen determine a person's preference. As depicted in the table, a significant majority of the respondents accounting for (65.5%) accepted MPHT as their preferred choice as against Voluntary testing which attracted only (33.4%). On their opinion regarding MPHT as a government policy, an overwhelming majority (88.8%) are in support while only (6.7%) oppose the idea with the remaining 4.3% indifferent. It could therefore be concluded from the findings that majority of the respondents are ready to accept the MPHT as a government policy.

The findings from the interview concur with the quantitative data. Some of the participants responded;
If the government will make such a policy it's okay with me because life is uncertain nowadays. It is the responsibility of the government to protect people from the disease, and the only way is to make such a policy so that it will monitor every marriage contract and ensure compliance (IDI: 26 year old Muslim male).

To me it will be right, because it will help curtail the spread of the disease (IDI: 22 year old male Christian) If the government will come in it is going to be a welcomed development. (IDI: 29 year old Muslim male).

It will be very good and will help a lot of people. (IDI: 23 year old female Christian).
It is going to be a good policy and the government would have done the right thing. (IDI: 18 year old female Muslim).

However, another Participant Observed
It will be good. But if the government is to come in, it has to consider that people with this [infection] need privacy. Therefore whoever is going to take charge in the implementation must be a person that can keep a secret. Because if people are being exposed there is going to be problem in the community, and the program will lose popularity. (IDI: 27 year old female divorcee).

These data shows that voluntary counselling and testing is not popular among the youth in Azare town and consequently its utilisation is low. On the contrary, MPHT appears to be more acceptable. However the issue of disclosure of test results appears to be more sensitive as privacy is opted in this respect. Some respondents are not ready to compromise their privacy hence any breach has the tendency of rendering the MPHT unpopular.

Effects of Stigmatization on Youth Acceptance of MPHT in Azare Town
This section examines the effect of stigmatization on the acceptability of mandatory premarital HIV test among the youth in Azare town Bauchi State. In the attempt to answer this research question, descriptive statistics was employed and the responses according to each question were presented together with some findings from the In-depth-interview. Table 4.5.1 presents the descriptive summary of respondents' attitudes in relation to stigma towards HIV/AIDS.

Table 4.5.1: Attitude of the Youth in Azare toward the MPHT

Questions	Responses	Frequency	Percentage
Premarital HIV test will create suspicion among couples	Yes	257	67.6
	No	113	29.7
	Undecided	10	2.6
	Total	**380**	**100**
Willingness to accommodate an HIV infected family member	Yes	231	61.6
	No	59	15.7
	Unsure/depends	85	22.7
	Total	**380**	**100**
People living with HIV/AIDS should be ashamed of themselves	Agree	198	52.5
	Disagree	149	39.5
	Undecided	30	8.0
	Total	**380**	**100**
Ever known a person with HIV/AIDS	Yes	297	79.2
	No	79	20.8
	Total	**375**	**100**
Feelings toward an HIV infected person	Disgust	44	14.8
	Indifference	83	27.9
	Sympathy	170	57.2
	Total	**297**	**100**
Do you personally know someone who has been verbally abused or teased because he/she is HIV positive?	Yes	133	36.2
	No	234	63.8
	Total	**380**	**100**
Readiness to cancel marriage plan should the partner refuse to be tested	Yes	340	89.4
	No	35	9.2
	Undecided	5	1.3
	Total	**380**	**100**
Reasons for yes	Sceptical	262	68.9
	Fear of gossips	65	17.1
	Undecided	13	3.4
	Total	**340**	**89.4**
Reasons for no	Personal wish	4	1.0
	No reservations	6	1.5
	Undecided	25	6.5
	Total	**35**	**9.0**
Rating of community attitude towards people living with HIV/AIDS	Positive	126	33.1
	Negative	187	49.2
	Indifferent	67	17.6
	Total	**380**	**100**

Responding to the question which sought respondents' opinions on whether couples are to undertake HIV testing prior to their wedlock will make them sceptical of one another, 67.6% answered in the affirmative, 29.7% disagreed while 2.6% remain undecided. On whether one would be ready to accommodate an infected family member, an overwhelming majority constituting 61.6% of the respondents are willing, 15.7% are not ready to extend such a gesture. However, this may not be ruled as a manifestation of stigma as other factors may equally be responsible for the non-readiness. In the same direction, another 22.7% had not taken a decision. The question statement which stated that people living with HIV/AIDS should be ashamed of themselves was highly stigmatizing, hence any response in the affirmative could be labelled as such. The table show that 52.5% of the responses agree with the statement, 39.5% disagree while 8.0% remain undecided. It could be inferred that even those who remain undecided entertain an element of stigmatization.

Clear options by the respondents themselves showed that out of the 79.2% that ever known a person with HIV, 14.8% have a feeling of disgust towards PLWHA. A significant 57.2% indicated 'sympathy' which could also be relative. It could be interpreted positively or negatively. Only 27.2% remain indifferent.

Similarly the data shows that out of the respondents 36.2% knew of an HIV positive who was verbally abused or teased because of his/her status. An IDI participant stated;

When some people realise that their partner is HIV positive they start shouting and insulting the person saying 'I don't know you are this and you are that' and so on. But that is not the best way to handle the situation (IDI: 23 year old female Christian).

Another Respondent Narrated;
There was an instance like this recently. One of my friends was becoming so frail and people started gossiping 'what is the matter with this guy or has he swallowed 'leather'? (IDI: 29 year old male Muslim).

In response to the question which inquired whether respondent will be willing to cancel his/her marriage plan should the would-be spouse refuse to submit to HIV testing, overwhelming majority 89.4% agreed, their reasons being; scepticism (68.9%) and fear of gossips (17.1%) those undecided constitute only 3.4%. The above data shows that stigmatization of HIV/AIDS exist in the study population, although a degree of compassion towards infected family members was acknowledged which stands at (61.6%). An IDI participant stated;

.....it happened to my sister who falls sick with her husband. He refused to go for testing and neither discussed the matter and only resorted to herbs. I took her to hospital for diagnosis and tested positive. I now take the responsibility of procuring anti-retroviral drugs for her. (IDI: 26 year old Male Muslim).

This coincides with a qualitative finding by Pindani et al (2014) which reported that in Malawi, like in many other African countries, the high prevalence rate of HIV has necessitated the introduction of home based care where high level of support comes from close family members. Invariably, family support is associated with better adjustment and coping treatment adherence during home based care of PLWHA.

Factors that Influence Attitudes of Youths in Azare, Bauchi State toward MPHT
This section aimed at investigating factors that may influence respondents' attitudes towards the MPHT. Many people have beliefs and behaviours related to health and illness that stem from cultural forces and individual experiences and perceptions. Health seeking behaviours are therefore not always based on the individual's cognitive awareness of perceived susceptibility to, and perceived threat of disease, but may sometimes be as a result of societal influence. In answering this question therefore attempt was made to examine the factors which influence youth attitudes towards the MPHT. The Table below depicts factors that affect youth attitude toward the MPHT in Azare town.

Table 4.6.1: Factors that Affect Youth Attitude towards the MPHT

Question	Response	Frequency	Percentage
Mention of premarital HIV test in religious congregations	Yes	265	69.7
	No	115	30.2
	Total	380	100
The general opinion	Positive	174	45.8
	Negative	42	11.0
	Indifferent	41	10.8
	Not responded	8	2.1
	Total	**265**	**69.7**
If no, how do you see the programme from your religious point of view?	In conformity	67	17.6
	In contradiction	5	1.3
	Liberal	9	2.3
	Not responded	34	8.9
	Total	**115**	**30.2**
Persuasion to go for premarital HIV test	On self-will	133	35.0
	Health personnel	75	19.7
	Peers	12	2.2
	Parents	116	30.5
	Religious Leaders	39	10.3
	Not responded	5	1.3
	Total	**380**	**100.0**
Have to seek permission before seeking preventive health measures	Yes	200	53.8
	No	172	46.2
	Total	**372**	**100.0**
Where is the nearest HIV testing facility located?	My community	237	68.7
	Neighbouring community	69	20.0
	State capital	39	11.3
	Total	**345**	**100.0**
Have you ever been tested for HIV?	Yes	101	26.6
	No	274	72.1
	Not responded	5	1.3
	Total	**380**	**100.0**
If you have not been tested before what was the reason?	Distance	13	6.2
	Cost	24	11.4
	Fear of the test Results	64	30.5
	Sceptical of its relevance	109	51.9
	Total	**210**	**100.0**

Table 4.6.1 shows that 69.7% of the respondents indicated having heard premarital HIV testing mentioned in their religious congregation with the general opinion being positive at 45.8%. The remaining 30.2% indicated that they never heard premarital HIV testing mentioned in their religious congregations. However when asked how they view it from religious perspective, 17.6% said the programme is in harmony with their religious teachings. Only 1.3% maintained that it contradicts religious teaching. By implication therefore, it can be concluded from the foregoing responses that religious believes impacted positively on shaping peoples' opinion regarding premarital HIV testing. This finding coincides with what obtains from the interview.

These Are What Some of the Participants Stated;
It (MPHT) is in compliance with religious teaching, it is not against it (religion) (IDI: 22 year old Muslim male).It is not against religion, it is a must (IDI: 23 year old Anglican).

It [MPHT] is acceptable and does not violate religious teaching. In Islam one should not harm others and should equally not be harmed. And whosoever is HIV positive and gets married without disclosing his/her status has actually harmed the other partner. And as stated in the Qur'an and Sunna whosoever harms a partner arbitrarily awaits punishment in the hereafter (IDI: 26 year old Muslim).

In our church...the Catholic Church, the couple will have to undergo test three times before the marriage is contracted...so in my religion if a person is HIV positive, he/she will not be allowed to marry an HIV negative person (IDI: 22 year old Catholic).

The above responses invariably show harmony of opinions irrespective of religious affiliation. It could be inferred therefore that both Muslims and Christians view the MPHT to be in accord with their religious teachings.

Responding to the question on persuasion to go for premarital HIV test, (35.0%) will take independent decisions, (30.5%) will submit on persuasion by parents, (19.7%) by health personnel, (2.2%) by peers, and (10.3%) by religious leaders, respectively. The data shows that parental influence supersedes any of the generalized others. It is therefore not surprising that another two hundred respondents (53.8%) indicated having to seek permission from their families before going to hospital for counselling or testing. Similarly, in response to the IDI question 'would you discuss your HIV status with someone', some participants revealed the following;

Yes...I prefer to discuss it with my family (IDI: 23 year old female, Igbo).

Yes, I'll discuss it with my parents. I can tell them whenever we are going to the test with my partner and whatever be the result I must tell them. If one of us tested positive my parents will advise me on what action will be appropriate (IDI: 22 year old male, Sayawa).

Yes...I'll discuss it with somebody with whom I share secrets with...like family members. You know this issue needs secrecy and it is not everybody that you'll discuss it with (IDI: 18 year old female, Fulani) ...except my parents (IDI: 22 year old male, Fulani).

However, one hundred and seventy two accounting for (45.3%) said they don't need permission to seek for medication. This may be attributed to one's dependence on or independence of the parents because some respondents have already established their families. As such they can take decision on personal health without necessarily consulting their parents. This was observed in the IDI as expressed in the following responses.

Sometimes when I am sick I used to tell my father before going to the hospital. He will ask me if I have the means [of paying for the bill] and if I don't, we go together and he pays the medical bill (IDI: A 22 year old single) Another had this to say I don't have to take permission from anybody, it's a matter of improving my health (IDI: A 26 year old married).

With regard to proximity to HIV testing facility, (68.7%) said the services are available in their community. There is a Federal Medical Centre located in Azare town which provides Elisa and Rapid test services to patients as well as to women on antenatal care. There is also a unit which provides voluntary counselling and testing (VCT) services. Despite the availability and proximity of these services in the community, only (26.6%) of the respondents ever get tested even for varied reasons which include marriage, antenatal, employment, medical diagnosis, and for the purpose of travelling, as indicated in their responses, while only (12.1%) tested voluntarily just for the purpose of knowing their status. The reasons those who had not tested gave include distance (6.2%), cost (11.4%), fear of the test results (30.5%) and sceptical of its relevance (51.9%). Those who know their status are more likely to take precautionary measures while those who refuse to be tested remain more vulnerable. Many people with HIV do not know they are infected because most of the symptoms are asymptomatic. The ones that manifests such as headache, feverish feelings, nausea and vomiting usually disappear within a few weeks and the person feels normal. This asymptomatic phase often lasts for years in some individuals. During this period, the virus continues to multiply and kills the cells of the immune system thereby leaving the infected person vulnerable to opportunistic infections.

Ethical Issues Relating to the MPHT

In answering this research question descriptive statistics involving frequency distribution was used. The questions aimed to address some ethical issues that relates to the MPHT by seeking people's opinions regarding disclosure and informed consent.

Table 4.7.1: Ethical Issues Relating to the MPHT

Question	Responses	Frequency	Percentages
Whether it is good for one to know his/her HIV status	Yes	331	87.3
	No	48	12.7
	Total	**379**	**100.0**
Disclosing HIV positive status when a third party is at risk	Yes	246	64.7
	No	134	35.3
	Total	**380**	**100.0**
Reason for yes	To prevent further infection	194	51.0
	It is an obligation	12	3.2
	Not responded	40	10.5
	Total	**246**	**64.7**
If no, who would you blame when transmission occurs	The client	67	17.6
	Health personnel	50	13.2
	Nobody	16	4.2
	Not responded	1	0.2
	Total	**134**	**35.2**
Emphasis when dealing with HIV/AIDS	Individual rights	108	28.8
	Public interest	164	43.7
	Government legislation	103	27.5
	Total	**375**	**100.0**
It is good to conduct HIV test before any marriage contract	Agree	330	88.2
	Disagree	22	5.9
	Unsure	22	5.9
	Total	**374**	**100.0**
Mode of disclosure	Confidential	172	46.0
	To authorities when someone is at risk	83	22.1
	To religious leaders	54	14.4
	To parents	21	5.6
	Total	**330**	**88.1**
Respondent's opinion about mandatory premarital HIV test	Positive intervention	281	75.1
	Breach of Human Rights	60	16.0
	Violation of medical ethics	33	8.8
	Total	**374**	**100.0**

In response to the question which inquired whether it is good for a person to know his/her HIV status, an overwhelming (87.3%) agreed while only (12.7%) disagreed. When asked whether it is ethical for health workers to disclose HIV status if an innocent third party is at risk, a significant percentage accounting for (64.7%) responded in the affirmative. Amongst them (5.8%) even consider it an obligation upon the health workers to make such disclosure. In the same direction one hundred and ninety four (94.2%) expressed that disclosure in such circumstance will prevent further infection. The above data revealed that majority of respondents do not consider it unethical to disclose HIV positive status when a third party is at risk. In dealing with HIV matters the responses show that majority emphasized public interest as against individual rights with (43.7%) and (28.8%) respectively.

Similarly, on the opinion of conducting HIV test prior to any marriage contract an overwhelming majority accounting for (88.2%) agreed while a not significant (5.9%) disagree with yet another (5.9%) undecided.

But regarding disclosure of the test result, majority of respondents constituting (51.2%) opted for confidentiality. It could be understood that people often want secrecy pertaining to sensitive health issues that are highly stigmatized such as HIV/AIDS. It could therefore be inferred that in spite of the acceptability of the MPHT among the study population (refer to table 4.4) it might lose popularity when disclosure is to be made public. One participant in the IDI observed;

...it would not be proper to just display the test results for everybody to see. Because there will be people who would be there just for gossips, and you know those affected will definitely feel bad (IDI: 27 year old female divorcee).

In relation to human rights however, the majority consisting of two hundred and eighty one respondents (73.9%) described it as positive intervention. while only sixty respondents constituting (15.7%) consider the MPHT as a breach of fundamental rights and thirty three (8.6%) view it as violation of medical ethics. This finding indicates that majority of the respondents do not have reservations on the MPHT vis-à-vis Fundamental Human Rights. This finding coincides with that of the interview. One participant expressed his opinion;

In my opinion this policy does not infringe on human rights. Only the deceitful will see it as a breach of human rights but the honest will see it as good (IDI: 29 year old Hausa male).

Another Participant Had This to Say
No it is not a breach of human rights. That is my opinion. You know, sometimes people don't foresee the wisdom in what leaders do, but that should not deter the leaders from doing what is right. Moreover a leader must protect his people from whatever harm (IDI: 26 year old Fulani male).

Another Participant Expressed
Some partners are just wicked and not really interested in getting married. They only want to destroy the life of their partner. As such they would not disclose their status until after the marriage. This has happened to a lot of people. But when they make it a law and become mandatory, it will help [protect] a lot of people (IDI: 23 year old Igbo female).

Another Participant Said
The government come out with a policy, enforce and coordinate it. As far as I am concerned it is just trying to improve the wellbeing of its people. Even if I tested positive and the government requested for the result I will definitely submit it in person. This will make me take appropriate measures and so on. I may even get assistance from the government (IDI: 18 year old Fulani female) .

The calculated chi-square (3.372) is less than the table value (9.488), as such we accept the null hypothesis (Ho) which states that perceived stigmatization does not adversely affect the acceptance of MPHT and reject the alternate hypothesis (H1) which states that perceived stigmatisation of HIV/AIDS adversely affects the acceptance of MPHT. Therefore at 5% level of significant the study concludes that perceived stigmatization and youth acceptance of the MPHT in Azare town are independent of each other.

Stigmatization/Acceptance of MPHT
This study also found that majority of the respondents (65.5%) showed willingness to accept the MPHT as a government policy. In this respect the study concur with the one in Ibadan by Arulogun and Adefioye (2012) which show acceptability of the MPHT at 82.8%. Makelele (2005) found among the Kitampo in Ghana that 94.7% expressed that they will consider health status as core criteria when choosing their marriage partners with 82.7% indicating willingness to go for premarital medical examination. A study in Iran among young couples referred to the premarital counselling centre (Shahcheraghi et al 2014) show that willingness to go for premarital HIV test stands at 69%.

The study also found that majority of the respondents indicated readiness to cancel marriage plans when their partners refuse to test for HIV accounting for 89.47%. The result from table 4.8.2 confirms the null hypothesis which states that perceived stigmatization does not adversely affect the acceptance of MPHT. This finding is supported in an In-depth interview with a 29 year old female divorcee who expressed her opinion if her premarital test proved discordant;

Hmmhm!....(hesitation), really it is not going to be easy. I will be pondering how to start all over again, and I really can't stop loving him. Actually, in my opinion, in as much as I will not be labelled as destroying my life, I will marry him even if he is tested positive and I negative.

Although there is a conditional phrase in the statement which could be translated to refusal for fear of stigmatization, however that does not deter the participant from her willingness to continue with the marriage plan. This finding concurs with what obtained in Iran where many prospective young couples (26.7%) would be ready to marry their partners even if they tested positive (Shacheraghi et al, 2014). Although it might be for the fact that most of the participants in that study are in courtship and have already taken a decision. This study also found out that the general attitude towards people living with HIV/AIDS (PLWHA) rates negative, positive and indifferent accounting for 49.2%, 33.1% and 17.6% respectively.

Arulogun and Adefioye (2012) found that more than half (56.7%) agreed that a person who tests positive has put the family members to shame while 35.4% also agreed that going for mandatory pre-marital HIV testing would make their status known publicly. Stigmatization of PLWHA is a problem that affects many societies around the globe.

Factors Influencing Attitude towards MPHT

The study also found that religious beliefs impact on shaping opinion towards the MPHT. From what obtains in the In-depth interview, both Muslims and Christians expressed that their religious teachings are in harmony with the MPHT. Previous researches have shown that a variety of premarital tests are found to be in conformity with religious teachings (Alswaidi and O'Brien 2009; Akani et al 2005). A study by Rennie and Mupenda, (2008) found that the Roman Catholic Church in Burundi instructed its priests only to conduct wedding ceremonies if the couples present an HIV test which is conceived as integral to a holy union. Religious bodies exert significant influence on shaping attitudes toward HIV interventions. These were reported regarding condom use in Nigeria (Policy Project, 2004; Umar and Oche, 2012) and Tanzania (Diggos, 2008). Parental influence was also found to be significant in shaping opinion towards the MPHT and is rated second to self-will which accounted for (35.0%), on persuasion by parents (30.5%), by health personnel (19.7%) by peers (2.2%), and by religious leaders (10.3%) respectively. It could therefore be inferred that religious factors and parental influence have remarkable impact on shaping attitude towards the MPHT.

This study also found that utilisation of voluntary counselling and testing (VCT) is very low with only 12.2% ever tested voluntarily. The reasons for not testing include; distance (6.2%), cost (11.4%), fear of the test result (30.5%) and sceptical of its relevance (51.9%). This finding coincides with the one by Diggos (2008) which reported that only 14% of Tanzanians aged 15-49 years went for VCT. Another study by Yahaya et al (2010) found that ignorance (3.2%), fear of being positive (3.1%), cost of VCT (2.8%), inadequacy of VCT centres (2.5%) stigmatization (2.1%), discrimination (1.9%), religious belief (1.6%), cultural belief (1.3%), parental pressure (1.2%) and Inadequate motivation (1.1%) were expressed as factors hindering acceptance of HIV/AIDS VCT. In a study among tertiary students in Anambra, Mbamara et al (2013) reported that those who oppose VCT accounted for 20%. Their reasons being that they cannot bear the results (25.3%), lack of confidentiality in VCT (23.3%) and that VCT is not necessary because even if one knows his/her status, the virus has no cure (20.0%). In the same direction, Ugochukwu et al (2014) studied knowledge and utilisation of VCT among tertiary students in Abia and found that of those who refused testing, 37.1% are not aware of where to get the test, 22.9% fear the test result, while 8.6% would not test because of stigma. These findings however, differ with the one by Gatta and Tshweneagae (2012) who found among adolescent high school students in Ethiopia that 83.86% knew of VCT services. Majority (64%) of those who knew about the VCT services had been tested and knew their HIV status.

Ethical Issues Relating to the MPHT

On disclosure of the test results when a third party is at risk, this study found that majority (64.7%) do not consider such a disclosure as violation of ethical norms. However, (51%) prefer the disclosure to be confidential under normal circumstances. This coincides with the findings of a study by Pool et al (2001) among pregnant women in rural Uganda which found that the women were willing to accept HIV testing if confidentiality was maintained. In another study in Malawi, Misiri and Muula (2004) found that those that preferred maintenance of confidentiality if diagnosed to be HIV positive were more likely to accept HIV testing prior to marriage. Interestingly, people required confidentiality regarding HIV test results if they were to undergo HIV testing. However, once HIV testing has been suggested as a prerequisite for marriage, and consequently the marriage is cancelled due to HIV infection of one of the partners, secrecy may no longer be possible to maintain. Because there may be suspicion, rumour, and allegation that one of the partners is likely to be HIV positive.

Conclusion and Recommendations

This research work aimed at examining attitude of youths towards mandatory premarital HIV testing in Azare town. The study concludes that low knowledge of ways of contracting HIV is evident although awareness on youth vulnerability to HIV infection is significantly high. Acceptability of the MPHT as a government policy is expressed by the youth to the extent of cancellation of marriage plan should a partner refuse to test. Most youth however, prefer confidentiality in the disclosure unless a third party is at risk. Therefore this study concludes that despite fear of stigmatization consequent from public disclosure, yet the MPHT proved acceptable among the youth as a promising intervention.

Recommendations

In line with the aforementioned, the following recommendations are made;

1. Being among the vulnerable population, there is greater need to sensitize the youth on HIV prevention.
2. Community outreach programmes should be reinforced; sex education should also be reviewed and modified for inclusion in the curriculum in line with the existing circumstance.

3. Religious leaders should be incorporated in HIV interventions because they exert significant influence on shaping people's attitude. Once educated, they can help remove the misconceptions and the stigma people have towards HIV/AIDS.
4. In cognisance of their position as significant others, parents have to be sensitized to actively participate in educating their children on HIV issues.
5. There is need for the establishment of premarital counselling units to advice and counsel intending couples during courtship.
6. Voluntary counselling and testing (VCT), where informed consent is the norm, should be popularised.
7. Disclosure of HIV test results should not be made public. Public disclosure will invariably increase stigma rather than curtail it and consequently the objective of the test would be defeated.

References

1. Abdullahi, S. A. (2009), HIV/AIDS: Knowledge and reactions. In S. A. Abdullahi, I. Z. Mohammed and C. Casey (Eds.), Studies in cultural sociology. (pp. 244-256). Ibadan:Foludex Printers.
2. Abiodun, J. O. (2012), Leadership, development and health challenges in Africa: a case of HIV/AIDS. International Journal of Social Sciences. 8(2).
3. African Youth Charter (2006), The seventh ordinary session of the assembly held in Banjul, Gambia.
4. Akani, C. I., Erhabor, O., and Babatunde, S. (2005), Premarital HIV testing in couples from faith-based organisations: experience in Port Harcourt, Nigeria. Nigerian journal of medicine. 14(1):39-44
5. Alswaidi, F. M. and O'Brien, S. J. (2009), Premarital screening programmes for haemoglobinopathies, HIV and hepatitis viruses: review and factors affecting their success. Journal of Medical Screening. 16(1):22-28.
6. Amzat, J. and Razum, O. (2014), Medical sociology in Africa. Heidelberg: Springer.
7. Anderson, M. L. and Taylor, H. F. (2005), Sociology – understanding a diverse society. Belmont. Thomson Wadsworth.
8. Arulogun, O. S. and Adefioye, O. A. (2010), Attitude towards mandatory pre-marital HIV testing among unmarried youths in Ibadan northwest local government area, Nigeria. African Journal of Reproductive Health. 14(1):83-94.
9. Bauchi State Agency for the Control of HIV/AIDS, Tuberculosis, Leprosy and Malaria (BACATMA), (2009), Bauchi state HIV/AIDS strategic plan 2010-2015. Bauchi. BACATMA.
10. Bauchi State Gazette, (2011), Additional district heads and village areas. Bauchi state government publication.
11. Centre for the Right to Health for the Policy Project (2003), Background Paper for HIV/AIDS Policy Review in Nigeria. Policy.
12. Cockerham, W. C. (2011), Medical sociology (12th edn). New Jersey: Prentice-Hall.
13. Diggos, H. A. (2008), HIV transmission within marriage: findings from Tanzania. Unpublished.
14. Federal Republic of Nigeria, (2001), National youth policy and strategic plan of action. Abuja. The Presidency.
15. Gatta, A. A. and Thupayagale-Tshweneagae, G. (2012), Knowledge of, and attitudes towards, voluntary HIV counselling and testing amongst adolescent high school students in Addis Ababa, Ethiopia. Curationis. 35(1):103,8pages.
16. Kowal, S. And O'Connell, D. C. (2004), The Transcription of conversations. In U. Flick, E. Kardorff, I. Steinke (Eds), A companion to qualitative research. (pp. 248-252). London: Sage Publishers.
17. Makelele, J.K. (2005), Knowledge and perception towards premarital counselling and testing on human immunodeficiency virus infection among unmarried young adults in Kintampo district of Ghana. An MSc dissertation submitted to University of Ghana, Legon. Unpublished.
18. Mbamara, S. U. Obiechina, N. J. A. and Akabuike, J. C. (2013), Awareness and attitudes to voluntary counselling and testing (VCT) for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) among law undergraduates in tertiary institutions in Anambra State, Southeast, Nigeria. International Journal of Medicine and Medical Sciences. 5(6):290-294
19. Misiri, H. and Muula, A. S. (2004), Attitudes towards premarital testing on human immunodeficiency virus infection among Malawians. Croatian Medical Journal. 45(1):84-87.
20. National Agency for the Control of AIDS (NACA), (2014), Global AIDS response – country progress report. Nigeria GARR 2014. Abuja.
21. National Population Commission (2010), Population distribution by sex, state, L.G.A. and senatorial district. Abuja. National Population Commission.
22. National Population Commission, Bauchi office (2014), Projected population of Bauchi and Azare towns as at June, 2014.
23. Open Society Institute, (2014), Mandatory premarital HIV testing: An overview. New York. accessed on www.soros.org/ 7/5/2014

24. Peil, M. (1995), Social science research methods - A handbook for Africa. Nairobi: East African Educational Publishers.
25. Phillips, L. J. (1999), HIV and Ethics .The Canadian Psychological Association. Retrieved from: http://www.cpa/ethics.html 3/2/2014
26. Pindani, M., Nkondo, M., Maluwa, A. and Muheriwa, S. (2014), Stigma and Discrimination against People Living with HIV and AIDS in Malawi. World Journal of AIDS. 4:123-132
27. Policy project, (2004), Reproductive health issues in Nigeria: The Islamic perspectives. Pathfinder International.
28. Pool R, Nyanzi S, Whitworth JA. (2001), Attitudes to voluntary counselling and testing for HIV among pregnant women in rural south-west Uganda. AIDS Care.13:605-615.
29. Raosoft, A. (2004), Sample size calculator. Accessed on www.raosoft.com/samplesize.html.
30. Rennie, S. and Mupend, B. (2008), Ethics of mandatory premarital HIV testing in Africa: The case of Goma, Democratic Republic of Congo. Developing World Bioethics. 8(2):126-137
31. Shahcheraghi, S. H., Ayatollahi, J., Bagheri, M. A., Sarab, N., Sharifi, M. R. (2014), Acceptability of HIV/AIDS testing among premarital couples in Iran. Nigerian medical journal. 55(4):294-298.
32. Turnock, B. J. and Kelly, C. J. (1989), Mandatory premarital testing for human immunodeficiency virus: The Illinois experience. The Journal of the American Medical Association. 261(23): 3415-3418.
33. Ugochuku, U.O, Obiageli, F.E, Abali, C., Okezie, O.K., Uzo, E.E., Nkiru, O., Chidinma U., Emmanuel, N. (2014), Knowledge and utilization of HIV counselling and testing among students of a tertiary institution in Abia state, south east Nigeria. Journal of HIV and Human Reproduction. 2(1):8-14
34. Umar, S. A. and Oche, O. M. (2012), Knowledge of HIV/AIDS and use of mandatory premarital HIV testing as a prerequisite for marriages among religious leaders in Sokoto. Pan African Journal. 11(27).
35. United Nations Population Fund, (2014), UNFPA Nigeria; young people. World Health Organisation, (2013), World health statistics 2013. Geneva: WHO press. Available on www.who.int
36. Yahaya, L. A., Jimoh, A. A. and Balogun, O. R. (2012), Factors hindering acceptance of HIV/AIDS voluntary counselling and testing among youth in Kwara state. African Journal of Reproductive Health. 14(3):159-164.