



KNOWLEDGE OF HIV/AIDS AMONG YOUTHS IN A SEMI-URBAN COMMUNITY

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Abstract

HIV/AIDS remain one of the global health challenges threatening humanity. One of the effective ways to curtail its spread is to sensitize people on preventive measures. The youth constitute the vulnerable group hence examining their knowledge of HIV/AIDS and ways of prevention is paramount in any intervention. This study was a cross-sectional descriptive survey aimed at examining knowledge of HIV/AIDS among youths in semi-urban community in Nigeria. The population of the study included all persons aged 15-35 years residing within the metropolis at the time the research was conducted. 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. Quantitative and qualitative methods were used to analyse the data which involved descriptive statistics and content analysis respectively. The findings show inadequate knowledge of HIV among the youth as only 15.3% have full knowledge of ways of contracting HIV. Misconceptions about ways of contracting HIV/AIDS were evident as utilization of VCT services was very low (12.2%). The study recommends, among others, that sex education should be reviewed and modified for inclusion in the curriculum in line with the existing circumstance. Similarly, religious leaders should be incorporated in HIV interventions because they exert significant influence on shaping people's attitude.

Key words: HIV, Knowledge, Youths.

Introduction

One of the current health challenges threatening humanity is the Human Immunodeficiency Virus (HIV), a virus that causes Acquired Immune Deficiency Syndrome, (AIDS). The virus is spread through contact with bodily fluid such as blood, semen, vaginal secretions, or breast milk of an infected person including vertical transmission through the foetus (Anderson and Taylor, 2005). The virus may remain inactive for years, but once activated the immune system of the body gradually gets weakened leaving the infected person vulnerable to some opportunistic infections that eventually leads to death (Calhoun, Light, Keller, and Harper 1998). The first case of AIDS in Nigeria was reported in 1986. Consequently, the Nigerian government adopted the system of sentinel surveillance in assessing the prevalence of the epidemic which continued to rise from 1.2% in 1991 to 4.6% in 2008. Out of the estimated 35.3 million HIV infections worldwide, 3.2 million infected persons are in Nigeria which ranks second in the world HIV prevalence (World Health Organisation [WHO] 2013; National Agency for the Control of AIDS [NACA] 2014). In another report, an estimated sixty percent of new HIV infections in Nigeria occur in youths aged 15 to 25 years (United Nations Population Fund [UNFPA] 2014).

Knowledge of HIV/AIDS and its Modes of Transmission

The National Population Commission [NPC] (2013), in its national demographic health survey showed hardly any variation by background characteristics of men and women regarding knowledge of AIDS and awareness of modes of transmission of HIV as 93 % of women and 96 % of men in Nigeria know about HIV/AIDS. With regards the youth population however, the contrary is the case. Reports have shown that (UNFPA, 2014; NPC, 2013), only 33 % of male youths and 22 % female have comprehensive knowledge of HIV/AIDS. In the same direction, NACA (2014) reported that the percentage of young women and men aged 15–24 who correctly identified ways of preventing the sexual



transmission of HIV and who rejected major misconceptions about HIV transmission was 24% of the general population (NACA, 2014). Similarly, knowledge was slightly low in rural areas and among those with no education. The report also indicated that those who are unmarried and have never had sex were least likely to be aware of preventive measures than married men or those who have had sexual relationship. It could therefore be inferred from these reports that knowledge of HIV/AIDS and its modes of prevention are higher among adults than youths.

However, level of education sometimes proves to be a predictor of knowledge of HIV/AIDS among the youths. Studies by Mbamara, Obiechina, and Akabuike (2013), Ugochukwu et al (2014), shows that there is high knowledge of HIV/VCT among students of tertiary institutions in Nigeria which rates 71.4%, and 59.0% respectively. However, both studies were conducted in the South-east of Nigeria where awareness on HIV related issues rates higher than what obtains in the Northern part of Nigeria. Another study conducted by Fawole, Ogunkan, and Adegoke (2011) shows that a large number of the participants are aware of HIV/AIDS and have accurate knowledge of its modes of transmission. Respondents identified sex with an infected person (97.7%), sharing of unsterilized needle (95%), and unscreened blood transfusion (89.1%) as major means of contracting HIV/AIDS.

In Bauchi state awareness about the existence of HIV/AIDS is high and which stands at 87.2% for men and 94.9% for women (National Population Commission[NPC] 2013). Women appear to be more aware than men maybe because of their vulnerability. WHO (2013), identifies three main routes of HIV transmissions among general populace. Prominent among them is through all forms of sexual intercourse. The second most common mode of transmission is the exposure to infected blood through transfusion and needles sharing. The third major route of HIV transmission is the prenatal and substantial vertical (mother to child) transmission.

National Demographic and Health Survey NPC (2013) reported that knowledge on ways of prevention is low among the general population. The percentage of those who mentioned use of condom and limiting sex to one uninfected partner as preventive measures stands at 69.8 and 37.5 for women and 77.0 and 94.6 for men, respectively. Condom use is one among the three pillars of HIV prevention strategies; others are; Abstinence and Be-faithful, together they form the ABC strategy. However, the advocacy of condom use is not popularly acknowledged within marriage and among religious leaders (Umar and Oche, 2012; Orulogun and Adefioye, 2011).

Policy Project (2004), reported the views of Islamic scholars in Nigeria regarding condom use which says “Public promoting of condom use is not acceptable because it poses a detriment to abstinence as a major Islamic way to prevent STI/HIV/AIDS” (p. 17). This assertion was further confirmed by Umar and Oche (2012) who found in Sokoto that 64% of religious leaders, Muslims and Christians, would include total abstinence and mutual fidelity to their congregations while only 6.0% of Christian clerics would talk on condom use. In the same direction, condom use within marriage is neither popular. Diggos (2008) found in a study in Tanzania that among married women who reported to engage in high risk sex only 26.8% reported to use condoms. Similar trend appeared to married men who engage in high-risk sex, only 40.6% used condoms. The study noticed that acceptability of condom use within marriages is getting stiff opposition from the church. According to NPC (2013), condom use is much more frequent in urban areas than in rural areas (36 % compared with 11%) and increases with education, from 2.0 % among men with no education to 45 % among men with more than secondary education.



As Calhoun, Light, Keller, and Harper asserted “Sociologists study the transmission of disease in order to see how social factors contribute to it ... Such research can be particularly helpful in determining how social action might be modified to reduce the risk and incidence of the disease” (Calhoun et al., 1998, p. 381).

Research Design

This research used a descriptive cross-sectional study design aimed at examining the knowledge of HIV/AIDS among youths in Azare, Bauchi State. 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 statistical tools using measures of central tendencies. 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), 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 *n*th 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. The raw data were tabulated, 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.

Methods of Data Collection

This section explains the instruments used in the data collection. The data were collected using both Semi-Structured questionnaire and In-depth Interview guide (IDI Guide). The service of an expert was employed to that effect who studied both the questionnaire and the interview guide, and after discussing the contents and the objectives they aim to achieve, translated them into Hausa language. Participants were however given the option to choose the medium they prefer. This was to enhance proper understanding of the contents.

a) 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. 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, ways of transmission and prevention. Three hundred and eighty (380) questionnaires were self-administered by the researcher and trained assistants in accordance with the sample distribution.

b) 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 detailed 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 religious affiliation. 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.

Table-1: Distribution of Participants for In-Depth-Interview (IDI)

| Name of district | No. of participants | Description of Participants | | | |
|--------------------|---------------------|-----------------------------|----------|--------------|--------------|
| | | Marital status | Sex | Ethnic group | Religion |
| Azare district | 3 | Married | Male | Fulani | Islam |
| | | Single | Male | Sayawa | Christianity |
| | | Divorcee | Female | Hausa | Islam |
| Nassarawa district | 3 | Single | Male | Fulani | Islam |
| | | Married | Female | Yoruba | Christianity |
| | | Single | Female | Igbo | Christianity |
| Madangala district | 2 | Single | Female | Fulani | Islam |
| | | Married | Male | Hausa | Islam |
| Total | 8 | 8 | 8 | 8 | 8 |



Knowledge of HIV/AIDS among the Youth in Azare

This section examined respondents' knowledge of HIV/AIDS. The responses are presented in the tables below.

Table 2: Respondents' Knowledge of HIV/AIDS in Azare

| Question | Response | Frequency | Percentage |
|--------------------------------|----------------------|------------|--------------|
| Vulnerability to HIV infection | Old people | 17 | 4.6 |
| | Youth | 332 | 90.5 |
| | Children | 6 | 1.6 |
| | Promiscuous | 12 | 3.3 |
| | Total | 367 | 100.0 |
| Ways of contracting HIV/AIDS | Adequate knowledge | 58 | 15.3 |
| | Moderate knowledge | 137 | 36.1 |
| | Inadequate knowledge | 185 | 48.7 |
| | Total | 380 | 100.0 |

Table 2 depicts the descriptive data of respondents' knowledge of HIV. The data shows that majority of the respondents constituting three hundred and thirty-two (90.5%) know that the youth are most vulnerable to HIV infection. However, the question which asked respondents to identify ways of contracting HIV contains seven options including correct and incorrect statements. These are; (a) sharing of unsterilized sharp objects, (b) mother to child, (c) sharing toilets, (d) sexual intercourse, (e) handshaking, (f) mosquito bites and (g) blood transfusion. Multiple options were allowed. The responses were then classified into adequate knowledge, moderate knowledge and inadequate knowledge respectively. Those responses that indicated options a, b, d and g are classified as adequate knowledge. As displayed in table 2 above those who identified the correct ways of contrasting HIV are not significant as only fifty-eight respondents constituting (15.3%) chose the correct options. Many of the respondents erroneously believe that HIV/ AIDS can be contracted through sharing toilets or mosquito bite.

Table 3: Respondents' Knowledge of HIV/AIDS in Azare

| | | | |
|---|-----------------------------|------------|--------------|
| Whether HIV positives can live normally | Yes | 244 | 64.4 |
| | No | 135 | 35.6 |
| | Total | 379 | 100.0 |
| Reason for 'yes' above | Counselling and medication | 220 | 90.1 |
| | Destiny | 6 | 2.5 |
| | Does not kill instantly | 6 | 2.5 |
| | No response | 12 | 4.9 |
| | Total | 244 | 100.0 |
| Reason for 'no' above | Death row | 16 | 11.9 |
| | Due to organic malfunctions | 53 | 39.2 |
| | Anxiety and stigma | 51 | 37.8 |
| | No response | 15 | 11.1 |
| | Total | 135 | 100.0 |



When asked whether HIV positives can live normally, majority of the respondents (64.4%) answered in the affirmative, while 35.6% negated. Probing questions were further advanced to both responses. Of those who believed that HIV positives can live normally 90.1% indicated that HIV positives can stay healthy when they succumb to counselling and medication. This signifies positive knowledge in this respect. However few respondents constituting (2.5%) attributed it to destiny thereby interpreted it from a normative view point. Another 2.5% Of them suggested that HIV positives can live a normal life because it does not kill instantly while 4.9% did not respond. It could be inferred that there is an element of stigmatization in this response. Because people tend to have the wrong notion that HIV kills automatically. Similarly, different opinions were advanced as to why HIV positives could not live a normal life. Of the respondents that hold this view, 11.9% described HIV positives as being on a 'death row' which clearly depicts stigmatization, 39.2% considered organic malfunctions in HIV positives would hinder a healthy living while 37.8% identified anxiety and stigma as major barriers to a normal life. The remaining 11.1% did not respond.

Table 4: Respondents' Knowledge of HIV/AIDS in Azare

| | | | |
|---|-------------------------|------------|--------------|
| Whether a healthy-looking person can have the HIV virus | Yes | 274 | 73.1 |
| | No | 37 | 9.9 |
| | Don't know | 64 | 17.1 |
| | Total | 380 | 100.0 |
| Effective way of knowing HIV status | Counselling and testing | 344 | 91.2 |
| | Physical Appearance | 30 | 8.0 |
| | Spiritual Diagnosis | 3 | 0.8 |
| | Total | 377 | 100.0 |
| Whether respondent will eat with an HIV positive | Yes | 246 | 65.1 |
| | No | 132 | 34.9 |
| | Total | 378 | 100.0 |
| Reason for Yes | Not Contagious | 219 | 57.9 |
| | Sympathy | 21 | 5.6 |
| | No response | 6 | 1.6 |
| | Total | 246 | 65.1 |
| Reason for No | Not Comfortable | 71 | 18.8 |
| | Fear of Infection | 38 | 10.0 |
| | No response | 23 | 6.1 |
| | Total | 132 | 34.9 |
| Is the VCT only meant for persons infected with HIV? | Yes | 116 | 31.1 |
| | No | 255 | 68.9 |
| | Total | 380 | 100 |

Virtually all the responses indicated sexual intercourse as the common way of HIV transmission. This finding coincides with the results of the interviews. When asked to identify ways through which HIV could be contracted one participant responded;



The fastest way is through sexual immorality. Secondly, through using sharp objects like razor blades, needle and by sharing clippers in the salon. HIV can also be contracted through sharing tooth brush (IDI with a 23 year old female Christian, single).

Another participant had this to say;

It is contracted through barbing, nail cutting, sexual intercourse, this is all I know (IDI with a 22 year old male Muslim, single).

Another participant responded;

The disease is commonly contracted through sexual promiscuity. Because some married men leave their wives and go after other women. By this they get infected and transmit it to their wives. It can also be contracted through sharing of razor blades, through breathing, sharing of toilets or breast feeding (IDI with an 18 year old female Muslim, single).

Other participants responded;

Through sexual intercourse, kissing...eh...through saliva, if one takes too much saliva, it can be contracted through that (IDI with a 23 year old female Christian, married)

Through sexual intercourse, blood contact, also one [an infected person] can smear his/her blood on something, like apple, and infect another. (IDI with a 25 year old male Muslim, married).

Certain issues could be observed from these responses. Firstly, ‘sexual immorality’ and ‘sexual promiscuity’ as expressed in these statements connotes stigmatization borne out of the misconception that only those who are sexually ‘reckless’ get infected with HIV. Such misconceptions according to Giddens, Duneier, and Appelbaum (2005) is today one of the major obstacles to successful HIV/AIDS interventions. Moreover, researches (Pindami, Nkondo, Maluwa, and Muheriwa 2014; Diggos, 2008) have shown that some HIV positives contracted the virus from their married partners and hence they did not deserve to be stigmatized or discriminated against. Secondly, some participants erroneously believed that HIV could be transmitted through kissing and by sharing tooth brush and toilets. These misconceptions could further aggravate the potential for stigmatization due to fear of perceived infection, because people who hold such misconceptions are not likely to share toilets with people living with HIV/AIDS (PLWHA).

Findings from the Study

The findings show that the youth identified themselves as most vulnerable to HIV infection (90.5%) which actually coincides with previous reports (NACA, 2014). It also shows that knowledge on ways of contracting HIV is very low with the commonly identified routes of transmission being sexual activity and blood transfusion. Overall, 15.3%, 36.1%, 48.7% have adequate, moderate and inadequate knowledge respectively. A UNAIDS (2008) report indicated that in sub-Saharan Africa, the high prevalence of HIV infection is due to heterosexual intercourse as the main source of transmission and contains almost two-thirds of all young people living with HIV. A study in Ethiopia (Gatta and Tsweneagae 2012) among adolescent high school students showed that 46.0% correctly mentioned knowledge of three modes of HIV transmission, 10.5% mentioned four while only 10.8% mentioned the five modes of HIV transmission. This finding however is in contrast to what Fawole et al (2011) found in a study among students of tertiary institutions in Ilorin that 73.6% have adequate knowledge on the



ways of transmission of HIV/AIDS. This could be attributed to their high level of education. Similarly, Makelele (2005) assessed the knowledge and perceptions of unmarried youth towards premarital test in Kitampo Ghana and found high level of knowledge of HIV accounting for 97%.

Based on what obtains from the data, both qualitative and quantitative, the study brings out the following findings;

1. The data show that the youths are aware of their vulnerability to HIV infection (90.5%).
2. This study found that there is inadequate knowledge of HIV/AIDS among the youth in Azare town. The findings show that only 15.3% exhibited adequate knowledge in this respect. The most commonly identified routes are sexual intercourse and blood transfusion. Some respondents erroneously mentioned kissing, eating or sharing toilet with HIV positive as ways of transmission.
3. The study found that utilisation of VCCT services is significantly low. Only 12.2% ever tested voluntarily.

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. Stigmatization being a barrier to successful HIV intervention has to be eradicated. This could only be achieved through educating the populace.
4. 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.
5. In cognisance of their position as significant others, parents have to be sensitized to actively participate in educating their children on HIV issues.
6. Voluntary counselling and testing (VCT), where informed consent is the norm, should be popularised.

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