

Full Length Research Paper

Factors hindering acceptance of HIV/AIDS Voluntary Counselling and Testing (VCT) among youths in Kwara State, Nigeria

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HIV/AIDS has become a source of concern all over the world. The concern cannot be isolated from the devastating effects of HIV/AIDS on economic, social, political and technological development of any nation with a high prevalence rate. Nigeria is one of the countries with HIV/AIDS prevalence rate of over 4%. Despite this challenge, the patronage of Voluntary Counselling and Testing (VCT) is still very low. This study therefore examined the factors hindering the acceptance of VCT as expressed by youths in Kwara State. A total of 600 youths from the three Senatorial districts in the State were involved in the study. A survey instrument designed by the researchers was used to collect relevant information from the respondents. Among others, the study identified ignorance, poverty, inadequate number of VCT centres, stigma and discrimination as major factors responsible for the low patronage of VCT centres in Kwara State. Gender and religion had no significant influence on the respondents' views while place of residence had significant influence. The implications of the findings to medical practice and counselling were identified and discussed.

Key words: Factors, hindering, acceptance, youths, HIV/AIDS, voluntary counselling and testing (VCT).

INTRODUCTION

HIV/AIDS is a major source of concern all over the world as it constitutes a major source of death and a threat to national development. The virus has negative impacts on economic, social and political development of any nation that has its high rate (Alao, 2004). Nigeria is one of the countries with a relatively high prevalence of people living with HIV/AIDS in West Africa. Statistics indicated that at the end of 2007, an estimated 22 million adults and children in the sub-Saharan Africa were living with HIV. Also, an estimated 1.5 million Africans died from AIDS while 11.6 million African children became orphans as a result of HIV/AIDS. Specifically, as at the end of 2007, Nigeria had 2.6 million people living with HIV/AIDS, 170,000 died of AIDS and 1.2 million were orphaned (AVERT, 2009). Due to the deadly effect of HIV/AIDS, Nigeria's life expectancy dropped from 53.8 years for women and 52.6 years for men in 1991 to 46 years for

women and 47 years for men in 2007 (UNAIDS, 2008). About 80% of HIV infections in Nigeria are transmitted through heterosexual activities, 10% of the new HIV infections are transmitted through blood transfusions while another 10% HIV infections are transmitted through mother-to-child transmission and other HIV risk behaviours, such as circumcisions and incision of tribal marks (AVERT, 2009).

In Nigeria, HIV/AIDS is aggravated by inadequate sexual health education, inadequate voluntary HIV testing and counselling, unhealthy cultural practices and poor health care system (Jimoh, 2003; Alao, 2004). HIV/AIDS is a dangerous virus which destroys the body's immune system. It leads to a progressive loss of a specific type of immune cell called T-helper, or CD₄, cells. As the Virus multiplies in the body, it damages or kills the cells and weakens the immune system leaving the infected person vulnerable to various opportunistic infections and other illnesses (Jimoh, 2004; Lawal, 2008). Good health is an essential condition to meaningful national development. HIV/AIDS is a threat to life, thus individuals need to know

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their HIV status through testing. This is necessary because such a test helps to reduce transmission and involvement in risky sexual behaviours. It also promotes early treatment and adjustment (Jimoh, 2003; Oshi et al., 2007).

HIV/AIDS counselling involves educating a client or a group of clients on the control, management and prevention of HIV/AIDS. Counselling assists people to make informed decisions, cope better with life challenges, lead positive lives and prevent further transmission of HIV. Voluntary Counselling and Testing can be defined as a confidential face-to-face interaction between a professional counsellor and a client or a group of clients with a view of assisting the clients to make informed decisions and adjust effectively in life. HIV/AIDS counselling consists of three stages, which are pre-test counselling, post-test counselling and follow up (Yahaya, 2004). HIV/AIDS test involves a scientific analysis of a client's blood in order to determine his/her HIV/AIDS status. Both HIV/AIDS counselling and testing aim at assisting clients/patients to understand themselves, and adjust effectively to life challenges and contribute meaningfully to the development of the society. Several authors (Alao, 2004; Pignatelli et al., 2006; Jimoh and Abubakar, 2003) have noted that VCT is a key element to identifying HIV infected persons who could benefit from therapeutic interventions.

A team of South African researchers carried out a study on factors associated with participation in HIV voluntary counselling and testing among TB patients in a rural South African hospital. A total of 153 consecutive adult TB patients were enrolled in the study. Demo-graphic characteristics, knowledge, attitudes and beliefs regarding HIV/AIDS were measured in order to determine possible associations with the decision to accept or reject VCT (O'Donnell et al., 2004). In the study, education was found to be the most important predictor of refusal to participate in VCT. For instance, educated TB patients accepted VCT more than the illiterate patients. The belief that VCT participation led to better health care and that participants had sufficient privacy to make their decisions about VCT were significantly associated with the acceptance of VCT. The study concluded that reaching educated TB patients in rural South Africa with VCT programmes may require different outreach strategies than less educated patients (O'Donnell et al., 2004).

An investigation on the influence of self perception of HIV infection on youths' attitudes towards Voluntary Counselling and Testing services in Nigeria indicated that youths with low self perception were not inclined to reduce risky sexual behaviours or to seek HIV/AIDS counselling and testing (Oshi et al., 2007). Similarly, another Nigerian study Okpoto (2009) on the attitudes of the University of Ilorin undergraduates toward Voluntary HIV/AIDS Counselling and Testing revealed that the respondents had negative attitude towards VCT and gender, age, religion, course of study and marital status had no

significant influence on their attitudes. The study recommended that VCT centres should be established in tertiary institutions to enable students have access to VCT. A similar negative attitude was noted amongst students of higher institutions in Ilorin towards the use of antiretroviral agents (Jimoh et al., 2008).

A Ghanaian study showed that 76% of the sampled women reported no prior HIV counselling and 78% had never undergone any HIV testing. The study also indicated that the majority of the respondents were not accessing the available VCT services. It was also found that education, prior HIV testing and history of Sexually Transmitted Diseases (STDs) promoted respondents' acceptance of VCT (Holmes et al., 2008). Pignatelli et al. (2006) investigated the factors predicting uptake of VCT in a real life setting in a mother and child centre in Ouagadougou, Burkina Faso. The sample consisted of all pregnant women receiving ante-natal, group health - education at St Camilla Medical Centre, Ouagadougou. It was found that less than 20% of the sample accepted VCT. The HIV seroprevalence rate was 10.6%, while the uptake rate was independently associated with age, the number of previous pregnancies and the number of previous miscarriages.

The youth is characterized by strength and vitality which predispose the young to a high level of involvement in sexual activities and the attendant risks such as unwanted pregnancy, abortion and infection with Sexually Transmitted Diseases. According to Mishra (2005), young people are highly vulnerable to HIV and other STDs. He asserted that in many countries 60% of all new HIV infections are among the age group 15-24 years and stressed that the highest rates of STDs are usually found among the youths of ages 20 - 24 years followed by 15 - 19 years. It was estimated that in Nigeria 3.1% of people living with HIV and AIDS are between the ages of 15 and 19 years (UNAIDS, 2008). Although, the statistic is low, it is relevant that the views of youths are sought as regards factors hindering their acceptance of HIV/AIDS VCT in order to prevent the spread of the virus.

A recent study, reported that the level of awareness of HIV/AIDS in Nigeria is still low and thus, the attitudes of most Nigerians toward voluntary HIV/AIDS counselling and testing needs to be improved. For instance, UNAIDS (2008) revealed that in 2006, only 10% of HIV-infected women and men were receiving antiretroviral therapy and only 7% of pregnant women were receiving the treatment needed to reduce the risk of mother-to- child transmission of HIV (Lawal, 2008). An NGO, AVERT also reported that the Nigerian government has set up the National HIV/AIDS Strategic Framework to manage the nation's response from 2005 - 2009. Thus, by 2010 Nigeria aims at providing antiretroviral therapy to 80% of adults and children with advanced HIV infection and to 80% of HIV - positive pregnant women (AVERT, 2009).

The Nigerian government has displayed good intention and commitment to the reduction and management of

HIV/AIDS related problems but the objectives of the government as regards prevention, control and management of the epidemic may be unachievable, if Nigerians continue to display a negative attitude to voluntary HIV/AIDS counselling and testing. This is because report indicated that in 2006 only about 10% of HIV infected women and men were receiving antiretroviral therapy and only 7% of HIV infected pregnant women were receiving treatment to reduce the risk of mother-to-child transmission of HIV (The Population Council Inc, 2007). This report is a major source of concern and thus the study was designed to investigate the factors hindering acceptance of HIV/AIDS Voluntary Counselling and Testing (VCT).

Several studies (Jimoh et al., 2008; Okpoto, 2009) have been conducted on attitudes of people toward VCT but not much has been done on factors hindering the acceptance of VCT in Nigeria. This study is therefore designed to bridge the gap. Also, the study is different from the previous ones because it sought information directly from the youths who are one of the major stakeholders of VCT programmes. The study also compares participants' view of the factors hindering acceptance of VCT based on gender, religion and place of residence.

Research questions

In line with the identified problems, the following research questions were raised:

- (1) What are the factors hindering acceptance of HIV/AIDS VCT as viewed by youths in Kwara State?
- (2) Do gender, religion and place of residence influence the youths' views of the factors hindering acceptance of HIV/AIDS VCT?

Research hypotheses

- (1) There is no significant difference in the factors hindering acceptance of HIV/ AIDS Counselling and Testing as viewed by respondents based on gender.
- (2) There is no significant difference in the factors hindering acceptance of HIV/ AIDS Counselling and Testing as viewed by respondents based on religion.
- (3) There is no significant difference in the factors hindering acceptance of HIV/ AIDS Counselling and Testing as viewed by respondents based on place of residence.

METHODOLOGY

The research is a descriptive survey which involved administration of a questionnaire designed by the researchers titled "Factors Hindering the Acceptance of HIV/AIDS Voluntary Counselling and Testing Questionnaire" on the sample. The questionnaire has two sections. Section A contains items on demographic data (gender,

religion and place of residence) while Section B has ten items on factors hindering acceptance of HIV/AIDS Voluntary Counselling and Testing (e.g. fear of being positive, ignorance and stigmatization). It is a Four-point Likert Type Scale which required participants to indicate their level of agreement or disagreement with the items contained in Section B, using Very True (4), True (3), Not True (2) and Not Very True (1). The highest score was 40 (4 x 10) while the least score was 10 (1 x 10). The validity of the instrument was established using content validity procedure. The procedure measures the degree to which the item contained in a questionnaire measure the variables being studied (Hassan, 1995). Thus, three lecturers in the Departments of Counsellor Education, Gynaecology and Sociology, University of Ilorin, Nigeria assessed the instrument and certified that the items were relevant to the area of research for which they were designed. The reliability of the questionnaire was determined through the use of test re-test procedure. Whiston (2005) described test re-test reliability procedure as a method of estimating the reliability of an instrument through the administration of the instrument twice to the same group of individuals. According to the author, a reliability co-efficient is then calculated by correlating the performance on the first administration with the performance on the second administration. Thus, the instrument was administered twice at an interval of four weeks to ten selected secondary school youths. The two set of results obtained were correlated using Pearson Product Moment Correlation and a reliability co-efficient of 0.67 was obtained. Thus, the instrument was found to be reliable.

Prior administration of the instrument to the selected sample, the researchers obtained the lists of registered youth organizations from the Kwara State Ministry of Youths and Sports Development. The questionnaire forms were administered personally to the participants in the three Senatorial districts in Kwara State by the researchers and six trained research assistants and retrieved immediately after completion. No VCT was provided to the participants but they were informed of the purpose of the study and encouraged to fully participate. Permissions for the administration of the questionnaires were sought from youth leaders and parents of the participants who were minors. Participants who were above 18 years of age were given consent forms. The content of the form was read aloud and the purpose and procedure of the study were clearly explained to all the participants. All enquiries from participants were answered before they were asked to sign the copies of the consent forms if they were willing to participate. Participants who gave informed consent were administered copies of the questionnaire. Respondents who obtained 21 score were considered to rate the item true while those who obtained 20 score and below were considered to have rated the items untrue. The collected data were analyzed using Statistical Package for Social Sciences (SPSS 15.0) to obtain mean, standard deviation and t-test statistics at 0.05 level of significance. Research question one was answered using mean response. The participants' responses were ranked based on the aggregate for each of the item. The highest obtainable mean was four (4) while the least was one(1). The research question two was answered using t-test statistics.

Socio-demographic data

The local of the study, Kwara State of Nigeria had a population of about 1.8 million (National Population Commission, 2007). It is estimated that at least one fifth of the population would be youths. The World Health Organization (WHO, 2010) described a youth as a young person whose age is between 15 and 24 years. Thus, total of 800 youths within the age range were randomly selected for the study but only 600 questionnaires were validly completed and consequently analyzed using descriptive (e.g. mean and percentage) and inferential statistics (e.g. the student t-test). Two hundred copies of the questionnaire which were not fully completed

were discarded. The age of the participants ranged between 15 to 24 years while the mean age was 19 years. Sixty five percent (390) of the respondents were males while thirty five percent (210) were females. Also, Seventy seven percent (462) of the respondents resided in urban areas while twenty three percent (138) resided in rural areas. Twenty percent (120) of the respondents obtained primary school certificates; sixty six percent (396) had secondary school certificates while twenty four percent (144) had post-secondary school certificates.

RESULTS

Factors hindering acceptance of HIV/AIDS VCT

Figure 1 indicates the ranked mean scores of all the respondents on each item. It shows that the respondents ranked ignorance (3.22), fear of being positive (3.19), Cost of VCT (2.85), inadequacy of VCT centres (2.55) and stigmatization (2.15), Discrimination (1.90), Religious belief (1.63), Cultural belief (1.35), Parental pressure (1.20) and Inadequate motivation (1.18) as factors hindering acceptance of HIV/AIDS VCT. The highest mean is 4 (40/10) while the least mean is 1 (10/10). Table 1 indicates a calculated t-value of 0.77 and a critical t-value of 1.96 at 0.05 alpha level. Since the calculated t-value was less than the critical t-value the null hypothesis one was accepted. Thus, there was no significant difference between the two groups of respondents.

Table 2 shows a calculated t-value of 0.91 and a critical t-value of 1.96 at 0.05 alpha level. Since the calculated t-value is less than the critical t-value the null hypothesis two was accepted. Thus, there was no significant difference between the two groups of respondents. Table 3 indicates a calculated t-value of 3.04 and a critical t-value of 1.96 at 0.05 alpha level. Since the calculated t-value is higher than the critical t-value the null hypothesis three is rejected. Thus, there was a significant difference between male and female youths as regards to factors hindering acceptance of HIV/AIDS VCT.

DISCUSSION OF FINDINGS

The study indicated the main factors hindering acceptance of HIV/AIDS as ignorance, fear of being positive, cost of VCT inadequate number of VCT centres and stigmatization. The finding could be due to the information available to the respondents as regards to the experience of HIV/AIDS patients. In a similar study (Okpoto, 2009) it was found that undergraduates of the University of Ilorin had a negative attitude towards HIV/AIDS VCT.

The study also found no significant difference in the views of respondents as regards to the factors hindering acceptance of HIV/AIDS VCT based on gender and religion. This finding may be due to the efforts of governments and non-governmental organizations in creating awareness about HIV/AIDS and VCT. For instance,

religious organizations in Nigeria have put up programmes on HIV/AIDS awareness and the usefulness of VCT. Participants irrespective of gender and religion seem to be aware of HIV/AIDS, VCT and basic issues that are related to the virus. It was found that respondents' place of residence has significant influence on their views of the factors hindering acceptance of HIV/AIDS VCT. Respondents residing in rural areas had a significantly lower mean in their views on factors hindering acceptance of HIV/AIDS VCT, an indication that they viewed the factors differently from those in the urban areas. Participants from the urban areas seem to appreciate the hindrances better than their rural counterparts. This finding could be attributed to the opportunity available to the respondents in the urban areas especially access to information through the print and electronic-media. Lawal (2008) also found that the knowledge and attitude of his sample was significantly influenced by place of residence.

Implications of the findings

The implication of these findings is that counsellors and health personnel need to collaborate in order to remove obstacles in the acceptance of HIV/AIDS VCT. This can be done through awareness programmes especially in the rural areas. There is also the need to make VCT services available in urban and rural areas with little or no cost in order to reduce the spread of HIV/AIDS virus and provide treatment to victims.

Conclusion and recommendations

This study investigated the factors hindering the acceptance of HIV/AIDS VCT as viewed by the youths in Kwara State. It was found that ignorance, fear of being positive, cost of VCT, inadequate number of VCT centres and stigmatization constituted major hindrances to acceptance of HIV/AIDS VCT. Rural and urban participants differed significantly in their views on factors hindering acceptance of HIV/AIDS VCT. This indicated that more awareness should be created among rural youths on the need for HIV/AIDS VCT. HIV/AIDS requires collaborative efforts in view of its devastating effects. People should be encouraged to obtain information about their HIV status and seek prompt counselling and medical intervention. Governments should therefore establish more VCT centres in both rural and urban areas to bring VCT service to the door step of the youths.

Self-testing for HIV is being advocated as it removes the issue of confidentiality. This is similar to what obtains in self-pregnancy testing using the serology based test kit; this can be later followed by counselling in positive cases as may be deemed necessary. Government should make the VCT free in order to enhance the uptake of the

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