

Knowledge of STD/AIDS Among Nigerian Youths Not-in-School and Their Risk Reduction Behaviour

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INTRODUCTION

Efforts to find a solution to the AIDS pandemic so far has been characterized by the use of short-cuts that bring quick results. This has resulted in stereotyping certain categories of people as high-risk behaviour groups and thereby concentrating attention on them. These include homosexual and intravenous drug users in the industrialized countries and female prostitutes in developing countries. The most important route of transmission is heterosexual and globally the majority of people who will develop AIDS in the future will also be heterosexual. Chin notes that by the year 2000 around 90 percent of the global AIDS cases would be found in the general heterosexual population (Chin, 1992). Rutenberg et al. (1994) also established in Tanzania that heterosexual contact accounts for about 80 percent of all infections in the country. Heterosexual transmission is thought to be responsible for at least 80 percent of HIV infections in sub-Saharan Africa (AIDS in sub-Saharan Africa, 1992). Certain groups of people have, therefore, become marginalised and hence cut off from both mainstream heterosexual and targeted homo-sexual prevention campaigns. Incidentally, some of such marginalised groups have become the bridge along which the HIV escapes from the so called high-risk groups to the general population.

One major effect of earlier researchers' focus on high-risk behaviour groups is the fear and prejudice that has characterized AIDS globally. Some recent researchers have, therefore, called for the redirection of attention from the behaviour of individuals and groups towards institutions and environments within which they operate, thereby allowing the conditions within which the behaviour occurs to be studied (Muir, 1991). Cleland et al. have stated that pending the development of an effective vaccine or therapy for HIV/AIDS, behavioural change is the only means of averting the continued spread of the disease (Cleland et

al., 1992). They argued that the advent of effective biomedical prevention is unlikely to bring a complete solution to the problem, unless it is accompanied by changes in sexual behaviour.

Adolescents and young adults are generally believed to be at increased risk of becoming infected with HIV because they are in a stage of cognitive, physical and emotional development and experimentation with sex and drugs. Youths not-in-school in Nigeria, most especially those staying on their own, could be particularly vulnerable because they may engage in a higher-risk behaviour and because they may be alienated from social service providers and school systems. This puts them outside the AIDS information networks while they themselves lack the social support to change their behaviour. Despite the fact that the problem of youths not-in-school in Nigeria has not reached an alarming proportion, evidence abounds that they exist and are growing in number probably as a result of the prevailing economic situation. This group is in part the product of educational and economic reforms that took place under the country's structural adjustment programme introduced in 1987. Many parents could no longer afford the ever-increasing school fees payable in Nigerian schools and this might have forced many of these youths out of school.

Prior to the appearance of AIDS, the primary strategy used to control the spread of sexually transmitted diseases (STDs) among the sexually active relied on secondary preventive activities. Primary efforts to cause behaviour change through education were not actively pursued. However, increasing attention is now being focused on the medical risk to the young unmarried and sexually active of contracting STD and AIDS in particular. Youths not-in-school are of particular importance because many of them are out in the streets with very little parental or guardian support.

The present study therefore makes the youth not-in-school the focal problem. This is expedient

because many studies have indicated that youths are vulnerable to many health problems related to behaviour and environment (Berkley, 1992; Barnnet and Blake, 1992; Chin, 1992; Muir, 1991). Given the fact that sexual activity is the commonest way of spreading STDs and HIV infection, it is envisaged that the sexual behavioural characteristics of the youth and the environment within which they operate would have implications for the spread of the disease (Ogunjuyigbe, 1997). The study examines the knowledge of STDs/AIDS among youths not-in-school and their risk reduction behaviour.

THE DATA AND METHOD

This survey conducted between June and November, 1996 was carried out in Mushin and Idumota areas of Lagos state. These areas lie within the hub of brisk commercial activities which attract a teeming number of people during the day. A few makeshift structures add to the general atmosphere of sub-standard conditions. The youth paid money for the use of a makeshift bath house, to visit the toilet and even to sleep on the verandas. Some of the strong ones hired out mats for use on the veranda at night. The need to get money in order to survive has forced some of them to go into socially unacceptable means of earning incomes- the boys into the sale of marijuana, petty stealing and swindling. Some of the girls were forced into "survival sex". The legitimate activities for earning a living included portering and cleaning. A few sold petty items in the streets. Most of the youths did not have fixed daily schedules. The life of out-of-school youths in the area is thus one of continuous struggle for survival in an atmosphere of fear, intimidation, violence and vulnerability. Their environment, therefore makes them susceptible to infection and their limited resources reduce their capacity for health seeking decisions.

The target sample size was 250 respondents made up of 175 males and 75 females. The sample technique was mainly purposeful and covered those willing to provide information. A team of 5 interviewers and one supervisor carried out the survey. In each location one insider was contacted from among the target population and was used as the frontman. Using the insider made it easy to get the youth at the places and time convenient

to them for the interviews. To ensure a wider coverage, no place was visited twice.

While structural interview could usefully be employed to tapping information for the major thrust of the research objectives, focus group discussions (FGDs) were used to supplement the quantitative information on the issue. In this respect, four homogenous groups of six individuals each, selected on the basis of age and sex, were engaged in focus group discussions. These comprised six males and six females selected from the target population within ages 10-24 and six males and six females above age 24 who were outside the study group but within the same environment.

BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

Majority of the respondents fell within age group 20-24 (Table 1). Generally, the sampled population have low educational background and this was unlikely to provide them with favourable social and economic status. Males were seen to have been better educated than females. Sixty-two percent of male respondents compared with just 6.7 percent female population had secondary education. Majority of the respondents reported being in some work for a living. The occupations in which the respondents were engaged in were basically low income generating occupations which could not fully cater for their needs. Again almost all the occupations were those that could bring them into contact with several people who might take advantage of the vulnerability. Of particular interest is, the 33.3 percent commercial sex workers among the female population whose occupation would readily be associated with HIV/AIDS infection and spread. Majority of the respondents (51%) did not appear to have homes and had to sleep at various uncommendable places with market/school rooms taking the highest proportion of 38.8 percent followed by "Motor Parks" with 10 percent. There were not much difference between males and females regarding sleeping place outside home. Within their own environment therefore, both males and females would seem to be vulnerable to each other and both could also be easy targets of opportunistic individuals outside their environments.

Table 1: Percentage distribution of respondents by sex and socio-demographic characteristics

<i>Characteristics</i>	<i>Male N=(175)</i>	<i>Female (N=75)</i>	<i>Total N=250)</i>
<i>Age</i>			
10-14	9.1	6.6	8.4
15-19	38.3	46.7	40.8
20-24	52.2	46.7	50.8
Median Age	20.2	19.6	20.1
<i>Education</i>			
None	7.4	12.0	8.8
Primary	29.7	81.3	45.2
Secondary	62.9	6.7	46.0
<i>Religion</i>			
Christianity	60.0	72.0	63.6
Islam	20.6	13.3	18.4
Traditional	6.9	8.0	7.2
Others	12.5	6.7	10.8
<i>Occupation</i>			
Labourer	47.4	6.7	35.2
Petty Trading	27.4	29.3	28.0
Commercial Sex	-	33.3	10.0
Dressmaking/Barber	2.7	12.0	5.6
Mechanic	7.4	-	5.2
No Work	14.9	18.7	16.0
<i>Sleeping Place</i>			
At Home	47.4	53.3	49.2
Market	40.0	36.0	38.8
Motor Park	10.9	8.0	10.0
Restaurant	1.7	1.3	1.6
Hotel	-	1.3	1.3

Knowledge of STDs/AIDS

Respondents' knowledge of the mode of transmission of sexually transmitted diseases (STDs) and AIDS were presented in tables 2 and 3. They were asked to indicate 'true' or 'false' against each of the causes specified in the table. However, percentages provided are for only those who indicated 'true' for the given cause of transmission.

The responses on table 2 show that the respondents were quite aware of the proper mode of transmission of STDs. Male and female responses were also similar. However, the level of misconceptions was disturbingly high and females were more likely than males to hold them. For instance, the proportions which attributed the transmission of STDs to witches or wizards and act of God or to supernatural causes were 50.7 percent against 36.6 percent and 14.7 percent versus 6.3 percent respectively. In addition to the misconceptions the youths had about STDs, they did not regard them as serious ailments. Some even indicated

Table 2: Percentage distribution of respondents by sex and knowledge of transmission of STDs

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Through sexual contact	86.3 (151)	92.0(69)	88.4(221)
Through sex with prostitutes	91.4(160)	85.3(64)	89.6(224)
Through blood transfusion	62.9(110)	64.0(48)	62.8(157)
Witches/Wizards	36.6(64)	50.7(38)	40.4(101)
Through kissing	30.3(53)	26.7(20)	29.6(74)
Act of God/Supernatural	22.9(40)	14.7(11)	8.8(22)

Table 3: Percentage distribution of respondents by sex and knowledge of transmission of AIDS

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Through sexual contact	90.3 (158)	96.0(72)	89.2(223)
Through sex with prostitutes	89.7(157)	93.3(70)	90.4(226)
Through blood transfusion	74.3(130)	89.3(67)	78.8(197)
Witches/Wizards	53.1(93)	46.7(35)	51.2(128)
Through kissing	33.1(58)	82.7(62)	37.2(93)
Act of God/Supernatural	53.1(93)	46.7(35)	51.2(128)

that they still had sex just for enjoyment when they knew they had contacted some STDs. Table 3 also shows that most of the respondents knew about the proper transmission routes of AIDS. However, misconceptions about the mode of transmission were still held. These include kissing, caused by witches or wizards and by act of God or supernatural causes. Similarly, females were more likely than males to hold on to the last two misconceptions.

The study shows that respondents' awareness of STDs and AIDS is high with almost 98 percent of both sexes having heard of the diseases. About 22 percent reported of having been treated for STDs before, the male proportion being almost twice that of females; that is 26 percent and 15 percent respectively (table not shown). Close to one-fifth of the respondents had ever seen an AIDS patient. The level of knowledge of the early symptoms of STDs was also quite appreciable. Sixty-seven percent and sixty-six percent of males and females respectively mentioned discharge and pain in lower abdomen/genital organs respectively as some of the symptoms. It must, however, be emphasised that sexually transmitted diseases and AIDS are highly stigmatised in Nigeria and

persons infected are likely to keep the news to themselves. There is, therefore, reason to believe that the proportion which reported ever having STD or AIDS is on the conservative side. Evidence to this effect came up during the focus group discussions.

RISK-REDUCTION BEHAVIOUR

A very large proportion of the youth (89 percent) knew of condoms but just a third (34 percent) had ever used them. Only 6 percent always used condom in the last three months and another 19 percent used it occasionally. For those who used condoms, the main reason was to prevent venereal diseases. Just about 4 percent mentioned AIDS specifically. Another 40 percent said they used condoms to prevent pregnancy. The main reason for not using condom was that they 'just didn't like it' (33 percent). Another 11 percent felt that condom did not give them any protection. Some 5 percent did not use condoms because they had faith in their partners and a few others said they wanted babies (3 percent).

On whether there had been any modification in their sexual behaviour since hearing of AIDS, only 9 percent said they practised abstinence and another 10 percent said they insisted on the use of condom. What most of the youths regarded as changed behaviour, as presented in Table 4, included "no sex until partner was well known" (45 percent), "reduction in the number of sexual partners" (42 percent), and "avoidance of sex with prostitutes" (53 percent).

Table 4: Percentage distribution of modified behaviour since hearing of AIDS by sex

	<i>Male</i>	<i>Female</i>	<i>Total</i>
Avoid sex with prostitute	68.4	-	53.8
No sex until partner's well known	44.7	47.9	45.4
Reduced number of partners	40.4	45.2	42.1
Avoid anal sex	23.1	35.8	26.7
Asks for partner's behaviour	25.0	28.6	26.3
Avoid oral sex	18.9	32.4	22.4
Insists on the use of condom	8.6	13.6	10.8
Practice abstinence	10.1	8.7	9.6

DISCUSSION AND CONCLUSION

The results of this study confirm the earlier findings that the vulnerability of the youths conditioned by poor economic background latently

makes them least resistant to the spread of the infection. As Sabatier puts it "when the AIDS virus is introduced into a society it tends towards the path of least resistance" (Sabatier, 1987). This is often the path trod by the poorest, most disadvantaged, least-powerful or most stigmatised (Muir, 1991), the group youth not-in-school belongs.

The other worrisome side is that such group of people are usually cut off from AIDS campaign programmes. This is because their activities hardly come to light. Secondly, they do not operate in an organised form, so as to make them accessible for intervention efforts. Thirdly, the environment within which they operate, as place of work and sleeping place, will generally not expose them to general public campaign programmes through the electronic and print media.

The respondents showed a high knowledge and awareness of STDs and their mode of transmission. The same high level of awareness was reported in the specific case of AIDS. Almost all the respondents promptly mentioned sexual contact as the main mode of transmission of STDs and AIDS. However, virtually all of them qualified such sexual contact to be one with a prostitute; thus introducing some level of misconception into their knowledge. Another sign of misconception was shown in their belief that STDs and AIDS could be caused by witches, supernatural powers and through kissing.

The impression here appears to be that a respondent is likely to perceive himself or herself safe if he or she did not engage in these 'risk' habits or is not bewitched. In the circumstances of such perception, a respondent may be unknowingly spreading an infection he or she might have contacted from a perceived safe habit.

Regarding their risk reduction behaviour, although a very large majority of them knew of condoms, just about 6 percent used them in the last three months preceding the study. This could be said to be associated with their general belief that STDs and AIDS could be contacted through sexual contact but with those in commercial sex. Logically then, if one's partner is not seen as belonging to that category there would be no need for one to use condom.

It may be agreed that their risk reduction behaviour does not seem to offer any comfort regar-

ding implication for the spread of the AIDS virus. It is not only 'prostitutes' who spread the disease. In the process, the youths do not really adopt any effective risk reduction method mainly because they largely see the disease as that of prostitutes.

In the absence of any meaningful risk reduction behaviour, the youths may be spreading the disease possibly at a rate that no one imagines. Yet this is the group that no one takes notice of let alone taking intervention strategies. The youth may thus be one of the potential HIV distributors in the country.

Given that most of the behaviours of the youth not-in-school are to help them cope and survive in their adverse environment, AIDS intervention programmes must be innovative and follow an integrated approach. There is the need to take intervention programmes beyond prevention and treatment issues to include focus on the entire life style; that is the need for people to come to terms with how HIV infection affects other aspects of their lives, including their relationships with family, friends, and care providers.

Many of those affected or at risk are members of groups that often have a strong, historically based distrust of official information and outsiders who provide them. Intervention programmes must therefore have components of peer support and peer education. The basis of peer-to-peer education lies in opportunities it creates for sharing rationales, and possible solutions from the personal perspectives of the educators with those who are in similar circumstance, have similar experience and have similar problems. The willingness of individuals in a group to speak candidly from a personal perspective about the issues that affect the whole group fosters a trust that is not afforded to people in authority or those outside the group (Battjes and Pickens, 1988).

Beyond the need for specific programmes and services, there is a more fundamental problem that needs to be addressed. A frontal attack on the adverse social and economic factors associated with perpetuation of a cycle of poverty is called for in the long run. For it is known that HIV infection occurs, to a large extent, on a context of many other social ills including poverty, unemployment, inequality between sexes, drug and alcohol use. A study by Anderson and others has observed that increased knowledge

and more importantly, the behaviour skills were also to allow the individuals to refuse certain behaviours and negotiate lower-risk sexual activity (Anderson et al., 1996). A long-term solution therefore will be to address the adverse social and economic conditions that predispose them into the environment that fosters risk-taking behaviours.

KEY WORDS Sexual Contact. Risk Reduction Behaviour. Social and Economic Factors. Educational Programmes. STD. AIDS.

ABSTRACT This study investigated the knowledge and awareness of STDs/AIDS among Nigerian youths not-in-school and their risk reduction behaviour. Two hundred and fifty youths operating around Mushin and Idumota areas of Lagos State were surveyed. Results indicated that majority of the youths knew that STDs and AIDS are contracted through sexual contact. However, a significant proportion still hold the views that the transmission of STDs and AIDS could be due to witches/wizard or an act of God or supernatural causes. Though most of the youths believe that condoms can prevent STDs and AIDS, but just one-third had ever used them. The youths believe that avoidance of sex with prostitutes and reduction of number of sexual partners will save them from contacting STDs or AIDS. The results suggest that the adverse social and economic factors associated with perpetuation on a cycle of poverty which push many of these youths out of school should be attacked. It equally suggests that the youths not-in-school require a well organised and specifically targeted educational programmes.

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