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Women and the HIV/AIDS Epidemic: The Issue of School Age Girls' Awareness in Nigeria

By Solomon O. Momoh,¹ Ailemen I. Moses,² Maria M. Ugiomoh³

Abstract

This study was conducted to examine women and the HIV/AIDS epidemic: the issue of school age girls' awareness in Nigeria information was elicited from 1,222 randomly selected regular under-graduate female students from the 11 faculties of the University of Lagos, Nigeria, with the use of a standardized structured questionnaire. Results of the major objective of the study, that is the level of HIV/AIDS awareness among female undergraduate students, showed a moderate level of awareness, including other specific objectives of age, level of study and marital status. In contrast, at the graduate level—the 600 level of study—medical students showed a high degree of awareness, and it was only divorce as a sub-variable of marital status that showed a low level of awareness. The paper then made some recommendations, that what is needed in Nigeria is to address the cultural, biological and socio-economic conditions contributing to women greater vulnerability to HIV/AIDS epidemic.

Keywords: Nigerian women, HIV/AIDS, education

Introduction

Globally, when HIV/AIDS was perceived as a public health problem and declared and epidemic, the initial response was that of denial. Eventually the first case of AIDS was reported in Nigeria in 1986 by the Federal Ministry of Health (FMH, 2003). The Immune Deficiency Syndrome (AIDS), caused by the Human Immune Deficiency Virus (HIV) and spread mainly through sexual intercourse, blood transfusion with an infected person, breast milk, mother to child transmission etc., has attracted much concern from government, non-governmental organizations, as well as international communities.

Despite these, not less than 200,000 people lived with HIV/AIDS in 1980s; that number soared to three million by the mid-1980s and further rose to eight million by the end of the decade. But in the 1990s the increase was even more enormous, reaching 40 million people living with HIV/AIDS in 2001, (UN AIDS 2001). Sub-Saharan Africa with less than 11 percent of the world population is said to contain more than 70% of all HIV infected people. There are more than 28 million in the Sub-Saharan Africa, seven million in Asia, two million in Latin America and the Caribbean and three million in other regions infected with HIV/AIDS.

The prevalence trends in Nigeria showed that between 1993 and 1999 growth rates were 3.8% to 5.4% respectively (Achime 2000). Some parts of the country have been more affected than others; out of the 36 states of the federation and Abuja the

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Federal capital territory has the highest rates of prevalence. In some sites the prevalence was higher than 10%, and all the states have a general prevalence of over 1%. However, youths between the ages 20-29 years are more infected; though in the South-south and the South-west Zones, there were higher prevalence rates in the 15-19 year age group.

It is also increasingly well known that the spread of HIV is gender and age biased; young people are particularly susceptible to HIV infection, an estimated 11.8 million people ages 15 to 24 were living with HIV/AIDS at the end of 2001 worldwide (WHO 2002). Young people are vulnerable because they are likely to engage in high-risk behaviour, by having multiple sex partners, unprotected sexual intercourse among others. Gupta (2002) asserts that out of every 23 infected people, 13 infected are women, and this gender gap is specially pronounced among those who are younger than 25 years. Avert (2006), explains that the most recent survey of HIV/AIDS in Nigeria in 2003 showed, that 3.3 million were living with the scourge, of these, 1.9 million (57%) were females. This trend is largely due to ignorance, unprotected sex and the inability of women to negotiate condom use. Female adolescents are more afraid of pregnancy than contracting HIV infection, although this does not affect increased condom use. The South Africa Health Review (2000) stated that 97% of women have heard of AIDS, with 10% of women stating that staying with one partner and using condom during intercourse would not protect them against AIDS, while 21% still believe that transmission could take place by sharing public toilets; and 38% are of the opinion that HIV could be spread through mosquito bite. The foregoing data showed the low level of awareness of HIV transmission in South Africa, especially among women. In Nigeria it has been similarly discovered by the National Reproductive Health Survey (NARHS, 2003) in a study carried out in the country that males have a higher HIV/AIDS awareness than their female counterparts. In sub-Saharan Africa, Nigeria inclusive, it was discovered that there were 12 to 13 infected women for every infected men in 2001. The gender gap is especially pronounced among Africans who are younger than 25. In some African countries, infection rates are five times higher among younger girls than men (Population Bulletin 2002). Moreover, males are generally more aware of the various pathways of transmission of HIV infection as well as prevention than are females.

In Nigeria, studies of the university population are few despite the vulnerability of students to unsafe sexual practices. Arowojolu (2002) in a study on sexuality, contraceptive choice and AIDS awareness, discovered that women were more likely than men to have relationships with older partners, for monetary gains, maturity and understanding by older partners, as well as security. It was equally discovered that 60% had two or more current sexual partners. Kelly, (2000) in a study in Zambia discovered a marked decline in HIV prevalence rates in 15 to 19 years-old boys and girls with higher level of education, but an increase among those with lower level of education. The World Bank (1999) reports that education itself protects against HIV: the higher the socio-economic status and education the higher the control and prevention of HIV/AIDS infection.

Social-cultural norms, particularly gender norms often discourage people from using preventive measures in the era of HIV/AIDS, even when they risk contracting the virus. Norms encourage men to take sexual risks and also discourage women from questioning their partner's sexual activities (Population Report, 1999). By 1990, the female literacy rate in Nigeria was 39.5% compared to 62.3% for males (Lassa 1996).

The high illiteracy rate among Nigerian women is the consequence of the interplay of several factors, including sex stereotyping and forced early marriages. Adamu (1987) identified culture among the Hausa-Fulani of Northern Nigeria as the greatest problem for women's education. Available statistics by the Federal Ministry of Education (1985) taken between 1975 to 1984, a period when Universal Free Primary Education was in operation, indicate gender discrimination in access to basic education in the extreme North as compared to the Southern states. This trend had earlier been attributed to early marriage of females, a common phenomenon by the Hausa-Fulani ethnic groups (Kaita 1972). The low status of women and their lack of access to education may aggravate vulnerability to HIV infection. This is so because the accepted norm is for men to have extra marital relationships or to practice polygyny. These factors place women at higher risk for HIV infection. As well, gender inequality in many cultures had shown that women have less power than men in decision making processes. Most cultures prevent women from using contraception and preventative measures and even discussing these with sex partners. Asking a husband to use preventive measures requires that the wife plays a more assertive role than is the norm in most cultures (Population Report 1999).

According to Ali -Akpajiak and Pyke (2003), Nigeria is a male dominated society and women are seen as inferior to men. Women's traditional role is to have children and to be responsible homemakers. Their low status and lack of access to education increases their vulnerability to HIV infection. The most common route of transmission is through unprotected sexual intercourse, use of contaminated needles or syringes, blood transfusion, mother to child transmission during pregnancy and breast-feeding (Population Bulletin 2002). In many societies, women are expected and taught to subordinate their own interests to those of their partners. With such expectations, young women often feel powerless to protect themselves against HIV infection and unintended pregnancies (Population Reports 2001).

In Nigeria and elsewhere adolescents' sexual interaction is usually characterized by unequal power relationships between males and females. This is due in part because girls are usually socialized in early life to defer to boys even when they are in relationship. Boys have learned that as boys, they must be more aggressive and the girls more receptive with its attendant implications for the spread of HIV/AIDS. Even though The Centre for Disease Control (1988) finds that approximately 90% of students in the eight and tenth grades generally know that AIDS virus could be transmitted through sexual intercourse or by sharing a needle, socialization must be taken into account. Thus in an attempt to address the gap in literature concerning women, *education*, and HIV/AIDS, the issue of school age girls' awareness in Nigeria, this study makes use of demographic variables, such as age, marital status and academic level of study.

Two main objectives guided the study. The first was to find out the level of HIV/AIDS awareness of female undergraduates students at a Nigerian university. The second was to identify other specific variables of age, marital status and academic level of study on knowledge of HIV/AIDS.

Method

The study was conducted at the University of Lagos, Nigeria, founded in 1962 and is currently one of the largest in the country. Participants comprised of 1,222 randomly selected students from the nine faculties of the University; with a total

population of 12,230 females. This represented about 10% of the entire population, selected in proportion to the number of students in each faculty. A sample size of 10% of the entire population, according to (Gay 1987) if well selected can be representative of the desired population.

A total of 1,222 copies of the questionnaire were administered. The researchers obtained formal approval from each of the Dean of Faculty and Heads of Departments. With the assistance of course lecturers and two research assistants, copies of the questionnaire were administered in a classroom setting with 100% returns. The researcher assured the respondents of the confidentiality of information supplied emphasizing that the instrument has neither right nor wrong answers; and that it will be purely used for research purposes. The questionnaires were completed anonymously and respondents submitted their copies in a locked box provided for the purpose within each faculty.

Results

The presentation of the data includes the breakdown of the General Description of Research variables and personal information such as gender, age, academic level of study and marital status. The level of awareness was determined by a mean difference below 180, indicating a low level of awareness; a mean difference between 180-199 indicated a moderate level and 200 and above a high level of awareness. The instrument used, seeks demographic information of sex, age, academic level of study, marital status and faculty of study, which is the first part. The second part contained 60 items on a five likert scale.

This brings the maximum score to 300 and the minimum to 60. If a respondent scores above 180 to 199 her awareness may be termed moderate; 200 and above may be termed high, any score below 180 indicates low awareness. It was discovered at the 600 level of study a high level of awareness was found with a mean score of 2002.24 not at 24. Other variables of interests with moderate awareness, were gender, age, level of study (100-500 levels) marital status (single and married) had mean difference above 180 to 195.07 with the exception of Divorce which was below 180, a mean score of 178.67 and this was termed low.

Table 1 A General Description of Research

Variable: N = 1222

Variable	N	\bar{X}	SD	Remarks
Gender (Females only)	1222	184.44	24.89	Moderate awareness
Age { Youth 16-25 adult 26+	1047 175	184.44 185.23	24.84 26.83	Moderate awareness “
Level of Study { 100 level 200 level 300 level 400 level 500 level 600 level	297 243 349 286 30 17	180.71 181.99 185.31 187.16 195.07 202.24	25.05 24.25 21.31 29.47 11.40 12.26	Moderate awareness “ “ “ Moderate awareness High level
Marital Status { single Married Divorced	1049 169 4	84.82 182.07 178.67	24.83 22.94 31.36	Moderate awareness “ “

Discussion

The results do not show any significant mean difference between the youth 16-25 years (184.44) and the adults 26+, (185.23). It can be argued that all women of school age have heard of HIV/AIDS infection. This implies that awareness of school age girls is an important controlling tool of HIV/AIDS prevalence rate in Nigeria. This is so, because in spite of the prevalence differential among the 36 states, and Abuja the Federal Capital Territory, the general prevalence is just over 1% (Federal Ministry of Health 2003). Even The Centre for Disease Control (1988) asserts that young people age 16 to 19 years were aware that AIDS could be transmitted through sexual contact and infection through other non-sexual contacts.

The level of study shows a significant level of increasing awareness, from 100 level, with a mean score of 180.71, 200 level with a mean score of 181.99, 300 level with a mean score of 185.31, 400 level, with a mean score of 187.16, 500 level, with a mean score of 195.07 and 600 level, with a mean score of 202.24. This finding corroborates with that of National HIV/AIDS and Reproductive Health survey, carried out in Nigeria (2003) that awareness of HIV/AIDS among individuals increases progressively with increased education. Yet the correlation between awareness or education and protection against HIV/AIDS as indicated by the World Bank (1999) cannot be sustained by this data.

At the level of marital status, the single had a mean score of 184.82, the married a mean score of 182.07, and Divorced, a mean score of 178.67. The lack of significant mean difference, single status and married women, amplified the fact that both single and

married women are exposed to the same education, given in the same environment. HIV/AIDS awareness may not influence people's behaviour significantly, especially in Nigeria, where women have fewer powers than men in decision making when it comes to sexual matters. Population Reports (1999), found that in general, because women are dependent on men, it is more difficult for women to protect themselves.

Harmful marriage practices violate women's human rights and contribute to increasing HIV rates in women and girls. There is no legal minimum age for marriage in Nigeria and early marriage is still the norm in some areas, especially the northern part. Parents see this as a way of protecting young girls from the outside world and maintaining chastity. Many girls get married between the ages of 12 and 13 and there is usually a large age gap between husband and wife. Young married girls are at risk of contracting HIV from their husbands as it is acceptable for men to have sexual partners outside marriage and some men have more than one wife (Polygamy). Because of their age, lack of education and low status, young married girls are not able to negotiate condom use to protect themselves against HIV and STIs (Population Council 2004). Nigerian women are also exposed to HIV infection through traditional rites they have to perform at the death of their husbands. The widow's head is shaved with a blunt unsterilized razor blade. This may be an avenue of contracting the dreaded HIV infection. In the Western part of Nigeria women are required to drink the water that was used to bathe their late husbands' bodies. Traditionally, this is to prove the woman's innocence that she is not responsible for the man's death.

In Nigeria, even religion—Christianity, Islam and traditional religions—encourage discrimination against women. This gender discrimination in Nigeria increases women's vulnerability to the HIV epidemic, for they have to submit to their husbands' will irrespective circumstance or situation. The act of marriage in Nigeria means the woman has to be able to reproduce and much premium is placed on the fertility of women for the continuous survival of the society. In the process of child bearing, women may be exposed to HIV infection, especially in rural settings where modern facilities for ante-natal and post natal care may not be available.

Conclusion

The prevalence rate of HIV/AIDS is on the increase and the spread is gender biased. School age girls are more vulnerable, because of the likelihood of their involvement in high risk behavior. The lack of awareness, preventive measures, cultural practices and the socio-economic status of women are easy avenues through which women can contract the virus.

It is obvious, that there is a moderate level of awareness of the HIV/AIDS epidemic among University undergraduates. This awareness is more pronounced among students, of higher levels of education. Finally, the level of awareness in Nigeria of prevention, and intervention strategies of HIV/AIDS cannot be achieved without addressing those variables which are peculiar to Nigeria.

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