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Demographic variables and youths' response to community based HIV/AIDS counselling services in rivers state

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Abstract
The study investigated demographic variables and youths response to community based HIV/AIDS counselling services in Rivers State. Three research questions were answered and three null hypotheses were tested at 0.05 level of significance in the study. The study adopted ex-post facto research design. The population of the study consists of all the youths between the ages of 18-35 years spread across 30 community based HIV/AIDS counselling and testing outreach sites within the three LGAs of interest. There are 10 outreach teams per LGA. The sample size for the study comprised of 300 youths. The study used simple random sampling technique to draw 10 centers from the 30 community based counselling sites in each of the three LGAs. The instrument used for this study are Demographic Characteristic Questionnaire (DCQ) and the Youths Response to HIV/AIDS Cousnelling Services Questionnaire (YRHACSQ). Face and content validity of the instruments were done by two experts in measurement and evaluation, as well as two health educational administrators. The reliability of the instrument was determined through Cronbach alpha technique. The Cronbach alpha coefficient of 0.94 for HIV/AIDS counseling scale was obtained. Mean and standard deviation were used to answer the research questions while Independent t-test and One Way Anova were used to test the hypotheses. It was found that gender (male and female) significantly influence youths' response to community based HIV/AIDS counselling services. Youths in the age bracket of 15-25 respond most to HIV/AIDS community based counselling followed by those within 26-35 and finally those that were 36 and above. Also youths in the rural areas had a slightly more response to HIV community based counselling services than their urban counterparts. It was concluded that gender and location significantly influence youths' response to community based HIV/AIDS counselling services. It was recommended among others that social workers should be encouraged to have a perspective and orientation talk to youths in and around the community in order to redirect their negative attitude and perception towards HIV/AIDS counselling services.

Keywords: Youth, Gender, Age, Location, HIV/AIDS Counselling Services

Introduction

Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) affect all age groups but most especially, the youths who are the economically productive age groups in any society. Human Immune Deficiency Virus Infection and Acquired Immune Deficiency Syndrome (HIV/AIDS) is a spectrum of conditions caused by infection with the HIV. In the view of Nulty (2005) [6], young people (between the ages of 10 and 24 years) as well as adolescents (between the ages of 10 and 19 years) continue to be disproportionately affected by HIV/AIDS. This view was further emphasized when the Joint United Nations Programme on HIV/AIDS in 2016 (UNAIDS) [10] held that in 2014, 3.9 million people aged between 15 and 24 years were living with HIV/AIDS and 620,000 became newly infected with the virus. According to Nulty (2005) [6], HIV/AIDS is the leading cause of death among young people (aged 10-24) in Africa, and the second leading cause, globally. This is why Maughan-Brown (2010) [5] asserted that young people are at the centre of the global HIV/AIDS pandemic. Although there have been concerted effort from several governments as well as relevant organizations towards the reduction of HIV/AIDS, the sad part is that there is still no cure. UNAIDS (2016) [10] validated this stance when she held that although overall new infections have declined since 2010, the rate of decline is too slow to reduce annual new infections to 500,000 by 2020. This is because, the global response to the epidemic continues to be challenged by new infections, even with the scale-up of anti-retroviral treatment in low- and middle-income countries. This means that even if current progress in the fight against HIV/AIDS is maintained, new HIV infections- especially among young people are expected to increase. Conversely, if there is a stall in progress, the results could be devastating. Estimates suggest that as many as 740,000 additional adolescents could become infected between 2016 and 2030 (UNAIDS, 2016) [10]. In the absence of a cure for HIV/AIDS, several countries, including Nigeria, have implemented HIV/AIDS-Preventive Programs one of such is the HIV/AIDS Counselling and Testing (HCT) service.

HIV/AIDS counselling according to Alemu, Abseno, Degu, Wondmikun and Amsalu (2005) [2] is an activity undertaken by two people agreeing to fulfil the respective roles of "counsellor" and "client". This counselling prepares the client emotionally and socially for the personal and emotional process of receiving their HIV/AIDS test result through two sessions, namely pre- and post-test counselling. This is the main aim of HIV/AIDS counselling and testing. HIV/AIDS testing and counselling (HTC) is a critical and essential gateway to HIV/AIDS prevention, treatment, care, and support services and is the critical entry-point for engagement into treatment and care as well as for primary and secondary prevention efforts. This HIV/AIDS

preventive program provide people not only with a chance to be tested for HIV, but also to acquire knowledge on HIV and AIDS, enabling people to protect themselves and by extension, their loved ones against the infection. Therefore, there is an essential correlation between HCT and HIV/AIDS prevention. Lack of access to HCT services then can be said to be a serious barrier to HIV/AIDS prevention. If the young people who are especially vulnerable to HIV/AIDS are able to access these services, then it will reduce the burden of HIV/AIDS especially amongst the youths who are the future of the nation (Lippmann and James, 2003) [4]. Nulty (2005) [6] submitted that it is not enough that there is the provision of HIV/AIDS counselling and testing but it is more important for people to utilize these services.

The impact of HIV/AIDS is felt not only on the death as well as the level of the physical health of infected individuals, but also on the strain to public health facilities as well as psychological and social levels of the societies they inhabit as Arogundade and Faloore (2012) [3] observed. The enormous socio-economic implications of this disease is the reason why national governments continued to invest enormous financial as well as human resources in order to curb this malaise.

Youth has to do with the state or quality of being young. Youth health seeking behavior and responses to available health services like HIV/AIDS counseling are influenced by several demographic variables such as; gender, age and location.

Gender refers to the socially given attributes, roles, activities, responsibilities and needs connected to being a man (Masculine) and being a woman (Feminine) in a given time and as a member of a specific community within that society (Steinberg, 2001) [9]. According to him, gender roles are not biological rather they are socially determined roles for men and women. It therefore means that the term gender when applied to human beings draws a distinction between sexes (male/female).

Age refers to the period of time during which a person, animal, plant or phenomenon has lived or existed. For instance, it can be said that someone left school at the age of 18.

Location can be rural or urban. Rural areas are a community or countryside, where there is a continuous exodus of young people to the cities. The urban area is a cosmopolitan town or city having increasing population concentrations and improved social amenities.

Despite the introduction of different strategies of counselling and testing of HIV/AIDS by the World Health Organization and National Agency for the Control of AIDS (NACA) with a view to increasing the number of patients to be tested, the uptake of these strategies has been quite low; especially in Nigeria where voluntary Counseling service is being poorly utilized by the youths. Many opportunities to diagnose and counsel individuals at health facilities are therefore, being missed.

Identifying the influencing factors in the utilization of the service will enable the behavioral change intervention process to be more effective & efficient. This study therefore seeks to investigate Demographic Variables and Youths response to community based HIV/AIDS counselling services in Rivers State.

The study aimed at investigating demographic variables that influence youths' response to community based HIV/AIDS counselling services in Rivers State. The specific objectives explored were as follows:

1. To investigate the extent gender predicts youths' response to community based HIV/AIDS counselling services.
2. To find out the extent age predicts youths' response to community based HIV/AIDS counselling services.
3. To determine whether location predicts youths' response to community based HIV/AIDS counselling services.

The following research questions guided the study

1. To what extent does gender predict youths' response to community based HIV/AIDS counselling services?
2. To what extent does age predict youths' response to community based HIV/AIDS counselling services?
3. To what extent does location predict youths' response to community based HIV/AIDS counselling services?

The following null hypotheses tested at 0.05 level of significance guided the study

1. There is no significant difference between gender (male and female) on youths' response to community based HIV/AIDS counselling services.
2. Demographic variable of age does not significant predict youths' response to community based HIV/AIDS counselling services.
3. There is no significant difference between location (rural and urban) on youths' response to community based HIV/AIDS counselling services.

Method

The design for the study is ex-post facto. The population of the study consisted of all youths between the ages of 18-35 years spread across the 30 community based HIV counseling and testing outreach sites within the three Local Government Areas of interest to the researchers, namely Port Harcourt, Eleme and Obio-Akpor LGAs.

The study used simple random sampling technique to draw 10 centers from the 30 community based counselling sites in each of the three LGAs. Simple random sampling technique through balloting was also used to draw 100 youths aged 18 to 35years from each LGA. A total number of 300 respondents participated in the study, hence the sample size for this study was 300 youths.

The instruments used for the study were Demographic Characteristics Questionnaire (DCQ) and "Youth Response to HIV/AIDS Counselling Services Questionnaire" (YRHACSQ). The questionnaires comprised of demographic characteristics of gender, age and location and HIV/AIDS counselling services. The respondents were asked to tick as appropriate the options of their choice. The 10 item YRHACSQ was developed on a four point likert scale of Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD) weighted 4 points, 3 points, 2 points and 1 point respectively. Face and content validation of the instruments were done by two experts in measurement and evaluation as well as one health education administrator. The reliability of the instrument was determined through Cronbach alpha technique. The Cronbach alpha coefficient of 0.94 for HIV/AIDS counseling scale was obtained. Mean and standard deviation were used to answer the research questions while Independent t-test and One Way Anova were used to test the hypotheses at 0.05 level of

significance.

Results

Research Question 1

To what extent does gender influence youths' response to community based HIV/AIDS counselling services?

Hypothesis 1

Demographic variable of gender (male and female) does not significantly influence youths' response to community based HIV/AIDS counselling services.

Table 1: Mean and Standard Deviation Scores on the Influence of Gender on Youths' Response to Community Based HIV/AIDS Counselling Service.

Categories	N	$\bar{x}$	Sd	Df	t-cal	t-crit.	Sig.	Decision
Male	109	37.42	1.4	298	4.461	1.960	.000	Statistically significant (Reject Ho)
Female	191	36.56	1.69					

Table 1 revealed that the male youths have mean and standard deviation scores of 37.42 and 1.49 while their female counterparts have mean and standard deviation scores of 36.56 and 1.69 respectively. This showed that the male youths had a slight more response to HIV/AIDS community based counselling services than their female counterparts. In testing the hypothesis, the degree of freedom, t-test, and significant probability values were calculated to be 298, 4.46 and 0.00 which is statistically significant at 0.05 alpha level. Therefore, the null hypothesis is rejected. By implication, gender (male and female) does not significantly influence youths' response to community based HIV/AIDS counselling services.

Research Question 2

To what extent does age influence youths response to community based HIV/AIDS counselling services?

Table 2a: Mean and Standard Deviation Scores on Youths' Response to Community Based HIV/AIDS Counselling Services Based on Age

	N	Mean	Std. Deviation
Fifteen to twenty five	3	39.0000	1.00000
Twenty six to thirty five	59	37.8814	1.31418
Thirty six and above	238	36.5966	1.62947
Total	300	36.8733	1.65926

Table 2a revealed that youths within the age bracket of 15-25 had the highest mean value followed by 26-35 and 36-above. This shows that youths in the age bracket of 15-25 respond most to HIV/AIDS community based counselling followed by those within 26-3 5 and finally 36-above.

Hypothesis 2

Demographic variable of age does not significantly influence youths' response to community based HIV/AIDS counselling services.

Table 2b: One Way Anova on the influence of age on the youths' response on community based HIV/AIDS counselling services

	Sum of squares	Df	Mean Square	F	Sig.
Between Groups	91.740	2	45.870	18.625	.000
Within Groups	731.447	297	2.463		
Total	823.187	299			

Table 2b showed that the sum of squares for between groups and within groups are 91.74 and 731.45 while the mean squares for between groups and within groups are 45.87 and 2.46. With degrees of freedom of 2 and 297, the calculated F ratio value of 18.65 is significant at 0.00 when compared to an alpha level of 0.05. Therefore, the null hypothesis is rejected. By implication, age significantly influences youth response to community based HIV/AIDS counselling services.

Table 2c: Post Hoc Mean Comparison on the Influence of Age on the Youths' Response on Community Based HIV/AIDS Counselling Services

(I) age	(J) age	Mean Difference (I-J)	Std. Error	Sig.
Fifteen to twenty	Twenty six to thirty five	1.11864	.92880	.229
Five	Thirty six and above	2.40336*	.91174	.009
Twenty six to thirty	Fifteen to twenty five	-1.11864	.92880	.229
Five	Thirty six and above	1.28472*	.22823	.000
Thirty six and above	Fifteen to twenty five	-2.40336*	.91174	.009
	Twenty six to thirty five	-1.28472*	.22823	.000

Table 2c revealed that mean comparison of youths within the age bracket of 15-25 26-35 and 36-above are significant age combinations of youth response to HIV/AIDS community based counselling services.

Research Question 3

To what extent does location influence youths' response to community based HIV/AIDS counselling services?

Hypothesis 3

There is no significant difference between rural and urban influences on youth response to community based HIV/AIDS counselling services.

Table 3: Mean and Standard Deviation Scores on the Influence of Location on Youths' Response to Community Based HIV/AIDS Counselling Service.

Categories	N	$\bar{x}$	Sd	Df	t-cal	t-crit.	Sig.	Decision
Rural	177	37.14	1.5	298	3.41	1.960	.001	Statistically significant
Urban	123	36.4	1.77					

Table 3 revealed that the rural youths have mean and standard deviation scores of 37.14 and 1.52 while their urban counterparts have mean and standard deviation scores of 36.49 and 1.77 respectively. This showed that the rural youths had a slight more response to HIV/AIDS community

based counselling services than their urban counterparts.
In testing the hypothesis, the degree of freedom, t-test, and significant probability values were calculated to be 298, 3.41 and 0.00 which is statistically significant at 0.05 alpha level. Therefore, the null hypothesis is rejected. By implication, location (rural and urban) significantly influences youths' response to community based HIV/AIDS counselling services.

Discussion

The finding from Table 1 revealed that male youths had a slight more response to HIV/AIDS community based counselling services than their female counterparts. The possible reason for male youths to respond more than their female counterparts to HIV/AIDS community based counselling services could be as a result that male youths are easily allowed to attend gatherings by their parents more than the female youths. Male students had a high response because they are very much at liberty to move around than their female counterparts. This study contradicts the findings of Obi (2018) [7] who found that females make better responses to HIV/AIDS counselling services than males due to their lackadaisical attitudes to issue of interest.
The result of the study from Table 2a showed that youths in the age bracket of 15-25 respond most to HIV/AIDS community based counselling services followed by those within 26-3 5 and finally 36-above. Post Hoc comparison revealed that youths within the age bracket of 15-25, 26-35 and 36-above are significant age combinations of youth response to HIV/AIDS community based counselling services (see Table 2c). The possible reason for youths of the lowest age bracket attending HIV/AIDS community based counselling services could be that they are just coming up with much involvement in sexual and risky behaviours that can jeopardize their future, hence the hunger for orientation programmes on HIV/AIDS awareness enlightenment. The finding of this study is supported by the study of Owuche (2016) [8] who, in his study on age differential factors on youths' response to community based medical orientation on life threatening sicknesses, found that younger adolescents participate on community based medical orientation services than the older adolescents within the same locale. Also, the finding of Adeyemi (2018) [1] on the role of adolescents' age on responses to community based HIV/AIDS orientation programmes, was that older adolescents strongly repel any sensitization campaign that has come to quench their urge for risky behaviours.
It was found in Table 3 that youths in the rural areas had a slight more response to HIV community based counselling services than their urban counterparts. One possible explanation for this result is the influence of urbanization on the youths. The youths in the city claim to have received enough HIV sensitization through the social media since they enjoy regular electricity supply and better access to good network and internet connectivity. Again, youths in the urban areas think that they have received a lot of exposure to civilization, hence are civilized in their conduct. The present study is in line with the finding of Adeyemi (2018) [1] who, in a study to determine the comparative response of rural and urban adolescents on HIV/AIDS based counseling services, found that the youths in the rural areas respond to HIV/AIDS counselling session more than the youths in the urban. It was found in this study that location (rural and urban) significantly influenced youths' response to community based HIV/AIDS counselling services. The finding also depicts the fact that youths in the rural areas significantly participated in HIV/AIDS community based counselling more than their urban counterparts. This study contradicts the finding of Owuche (2016) [8] that youths in the urban areas respond and show high propensity to HIV/AIDS orientation services than their rural counterparts. The finding also contradicts the findings of Adeyemi (2018) [1] who reported that urban adolescents enroll more on HIV/AIDS counselling than their rural counterparts.

Conclusion

The researchers concluded that gender and location significantly influence youths' response to community based HIV/AIDS counselling services, and youths in the age bracket of 15-25 respond most to community based HIV/AIDS counselling services.

Recommendations

Based on the findings of the study the researchers made the following recommendations.

1. Social workers should be encouraged to have a perspective and orientation talk to youths in and around the community in order to redirect their negative attitude and perception towards HIV/AIDS counselling services.
2. It was recommended that the social health workers should employ the services of those who can speak both Pidgin English and that of the target audience in order to pass the message even to the uneducated.
3. The social health workers should be encouraged to have separate meeting points for male and female youths for optimum concentration and questioning where necessary.
4. More of pictures and videos should be used to intrigue the interest of the youths in order to fully participate in the counselling sessions.
5. A permanent counselling center should be set up both in the rural and urban areas to receive youths for community based counselling services.

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