



GLOBAL JOURNAL OF HUMAN SOCIAL SCIENCE
SOCIOLOGY & CULTURE

Volume 13 Issue 2 Version 1.0 Year 2013

Type: Double Blind Peer Reviewed International Research Journal

Publisher: Global Journals Inc. (USA)

Online ISSN: 2249-460X & Print ISSN: 0975-587X

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GJHSS-C Classification : FOR Code : 370199p



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Comprehensive HIV/AIDS Prevention Program Implemented by Students and Staff in Tertiary Institutions in Ekiti State, Nigeria

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Lessons Learned: Participation of staff and students is crucial in achieving the stated objectives of CHAPP as demonstrated during the Peer Education Training and a high turnout of staff during the mobilization of stakeholders. As a result of these, a partnership was formed between institutional structures which encourage periodic assessment.

Recommendation: Institutional leadership commitment, tertiary institutions HIV/AIDS policy, and developing a gender perspective that recognizes the greater vulnerability of women is highly recommend since they have crucial role to play in addressing the whole range of political, social, economic, legal and management implications of HIV/AIDS in higher education

Keywords : HIV/AIDS, education, tertiary institutions, prevention, Nigeria.

I. INTRODUCTION AND RATIONALE

Human Immunodeficiency Virus (HIV) and the resultant disease, Acquired Immune Deficiency Syndrome (AIDS), remain the foremost global health and development challenges. The rapid spread of HIV/AIDS in most of the Sub-Saharan Africa Countries over the past decade is no longer a health problem but

a major cause for the ongoing development crisis. The epidemic has cut life expectancy by more than ten years in several nations. Clearly, HIV/AIDS is one of the biggest threats to the achievement of the Millennium Development Goals agreed by all UN member states in September 2000¹.

According to Kelly *et al* (2006), HIV and AIDS confront us with two challenges:

- The disease: This is the medical and epidemiological condition of HIV infection and/or AIDS in individuals and communities.
- The developmental problem: This arises from the social and developmental impacts of widespread HIV infection, when infected individuals are found across a country or region.

HIV and AIDS will continue to cause fundamental social and economic changes that will affect educational opportunities and the demand for labour (Carr-Hill *et al*, 2002). In order to achieve the Millennium Development Goals 2-Achieve universal primary education; 3-Promote gender equality & women empowerment; and 6-Combat HIV/AIDS, Malaria & other diseases in 2015, it is highly imperative to address the impact of HIV and AIDS in the educational sector in Nigeria. The impact of HIV and AIDS on educators and students in tertiary institutions is problematic. Students in tertiary institutions in Nigeria are usually youth aged between 15-25 years where more than 60% of new HIV infections occur. This takes place against a background in which one-third of the country's population of about 160 million are aged 10-24 years (National Population Commission, 2007).

The risk of and vulnerability to HIV infections among women are particularly striking. This according to Obono & Mohammed (2010) can be explained by the patriarchal nature of the Nigerian society where there are gender differences in women's and men's roles and responsibilities and gender inequities in access to resources, information and power as reflected in gender differences and inequalities in women's and men's vulnerability to illness, health status, access to preventive and curative measures, burdens of ill-health and quality of care.

¹ See for Millennium Development Goals (2001); EFA Goals (2000); and UNGASS Declaration of Commitment on HIV/AIDS (2001).

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Corroborating the above, Glynn *et al* (2001) noted that in the middle of this HIV and AIDS debate is the growing evidence of the “feminization of the epidemic”, in which girls and women are becoming disproportionately infected with the virus. Although, there are a number of reasons why women might be more vulnerable to infection, many have suggested that the underlying gender inequality leaves women vulnerable to HIV. One of the pivotal responses to this claim has been to promote universal girls’ education in order to reduce HIV vulnerability.

AIDS has drastically changed the demands on educators, schools, and students, posing formidable challenges to education systems that are already overstretched and under-resourced. These new challenges-like the epidemic-are complex and require new ways of thinking and responding.

II. OVERVIEW OF HIV/AIDS IN NIGERIA AND EKITI STATE

The most populous country in Africa, Nigeria accounts for more than half of West Africa’s population, according to the U.S. Department of State. Nigeria’s first case of AIDS was diagnosed in 1986, and the national prevalence soon rose rapidly, from 1.8 percent in 1991 to a peak of 5.1 percent in 2001. (United Nations General Assembly Special Session [UNGASS], 2010). According to the report, 2,980,000 people are living with HIV/AIDS. After South Africa, Nigeria has the largest number of people living with HIV/AIDS in Africa. Women are disproportionately affected by the epidemic. Prevalence among young women ages 15 to 24 is higher than the prevalence among young men (2.3 percent versus 0.8 percent, respectively).

Figure 1 : Graphical Presentation of Trend in Nigeria

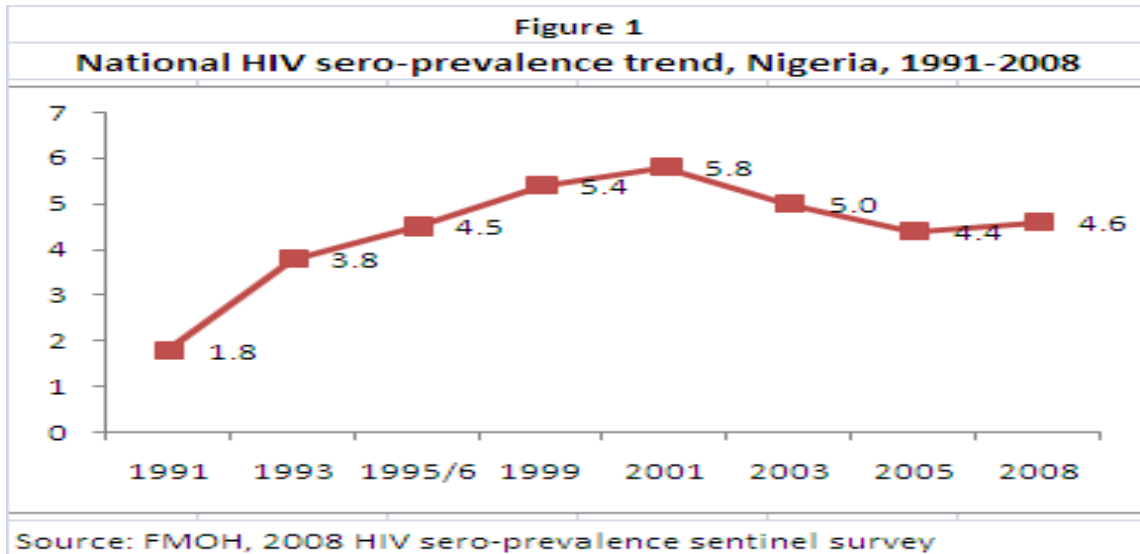
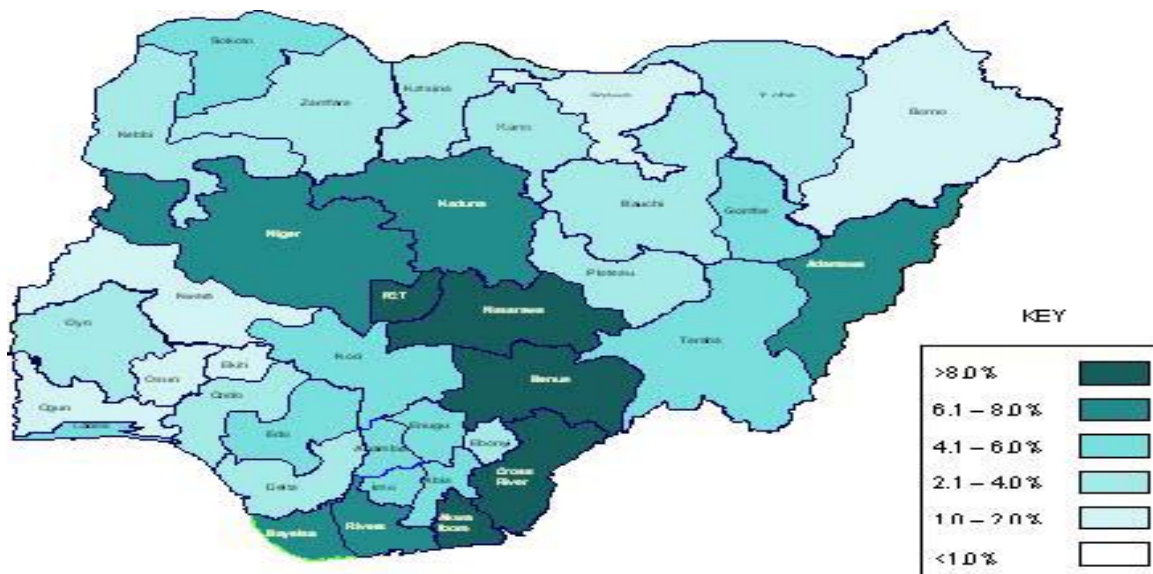


Figure 2 : Geographical distribution of HIV prevalence by States, 2008

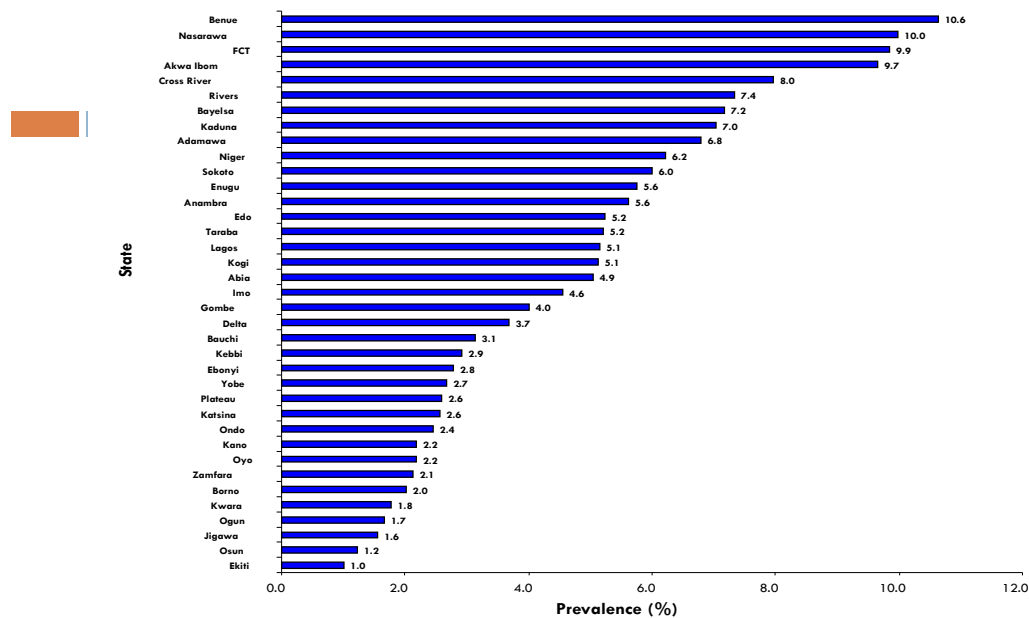


Source : 2008 National HIV sero-prevalence

Significant regional variation in the epidemic exists, with Ekiti State in the southwest geo-political zone of Nigeria having the lowest prevalence (1 percent), and

Benue State in the north-central zone having the highest (10.6 percent).

Figure 3 : Prevalence of HIV by Sates



Source : 2008 National HIV sero-prevalence

From the National Sentinel Surveys, since 2003, Ekiti State has witnessed decline in HIV prevalence rates (3.2% in 2001 to 2.3% in 2003, 1.6% in 2005 to 1% in 2008). According to Ekiti State HIV/AIDS Response Review (2004-2008), all the Local Government Areas and Communities in the Sate have records of HIV positive cases. Moreover, every community has seen at least a positive person, though most subjectively perceived. The age groups mostly affected are between 20-29 years and 30-39 years old. According to the 2002 estimated population of the State, these age groups constitute about 27% of the State's population. When put in numerical values, 827,856 persons are at risk of developing AIDS within the next few years without qualitative care and support.

The term 'drivers' of the epidemic in Nigeria refers to structural and social factors – poverty, gender inequality and human rights violations – that increase people's vulnerability to HIV infection. The following have been identified as the main drivers of HIV epidemic in Nigeria.

- ✚ Risky sexual behavior: this include
 - Early sexual exposure among young people
 - Unprotected sex among young people
 - Transactional sex
 - Low condom use in transactional/intergenerational and casual sex
 - Multiple sexual partnerships
- ✚ Poor perception of HIV risk
- ✚ Poverty

- ✚ Lack of effective STI programming
- ✚ Poor integration of HIV/AIDS and sexual & reproductive health services
- ✚ Gender inequality

The HIV situation in Nigeria is heterogeneous, with different parts of the country at different stages of the epidemic. One factor that is likely to be contributory is the variation in socio-cultural practices. Societal or community norm about sexual behavior substantially influences the risk of HIV transmission. However, Ekiti State is one of the most at risk States in Nigeria with heavy presence of higher institutions which earned her the name 'Fountain of knowledge', economic activities, and an influx of people. In contemporary times, western education had been the vogue throughout Ekiti. Ado-Ekiti took the lead with the number of educational institutions within a period of 50 years; much development in western education had taken place in Ekiti in general and in Ado- Ekiti in particular. Today, Ekiti sons and daughters are found in large numbers in every academic and professional position. Without doubt, education is the main industry of the Ekiti people.

III. HIV/AIDS AND EDUCATION

World Bank (2002) has reported that education is associated with the realization of six of the eight Millennium Development Goals (MDGs): reducing poverty, universal primary education, gender equality, reducing child mortality, improved maternal health and low HIV/AIDS prevalence. Education, therefore, has

profound potentials to integrate and scale up HIV/AIDS preventive efforts for female adolescents' reproductive and sexual health. For example, educated female adolescents are likely to delay marriage; have few healthy children; have good earning potential and personal skills, and so reduce sexual risks and exposure to HIV/AIDS (World Bank, 2002). Blum and Mmari (2005) identified education as one of the most integrative and effective HIV/AIDS protective factors.

Education is considered as a protection. The international community has made numerous commitments to women's literacy, getting more girls into school, and to ensuring that schools are providing empowering quality education. In the field of education and HIV and AIDS, there have been two opposing points of view in which some have argued that individuals with higher levels of education are more vulnerable to HIV (Kelly 2006), whereas others argue that more education (especially girls' education) protects against HIV infection (Global Campaign for Education 2004).

In highest prevalence countries, HIV and AIDS is affecting the supply of education, the demand for education, the quality of education and the way education is managed, and its capacity to respond to new and complex demands (Inter-Agency Working Group, 2001). It is a well known fact that education and training are critical for long term development of any country. Furthermore, the provision and growth of quality education is directly linked to positive economic development, emancipation and health dividends. However, HIV/AIDS is a real threat to the education sector and thus potentially to human resource-based development (Gachuhi, 1999). The effects of HIV/AIDS are multiple and have negative impacts on education.

However, one underlying assumption is that higher levels of education reduce HIV vulnerability for girls. Yet the evidence varies considerably from country to country, over time, and across regions. In the process of giving emphasis to the positive roles that schools can play in helping students and teachers to cope with the issue of HIV/AIDS, it is important to recognize that schools do not always represent safe environments, particularly for women and girls. A number of aspects of the school organization make them highly vulnerable.

IV. VULNERABILITY FACTORS OF STUDENTS TO HIV AND AIDS IN NIGERIA

According to Barnett & Whiteside (2002), the rationale of HIV infection growing faster is shaped by structural, social, socio-economic, sexual behavioral, individual contextual factors and biological vulnerability, which create inequalities in relations between groups of human beings. The existence of these factors creates imbalance and unequal exposure to HIV infection among various age groups and regions (UNAIDS/WHO, 2007).

HIV is a very serious threat to young people globally. It is important to tailor prevention strategies in the light of acknowledging the presence of factors that make young people vulnerable to HIV infection and to realize that HIV prevention will not be a reality if we fail to address the reality of the daily lives of young women (Ackermann & de Klerk, 2002). The lack of life skills and power imbalances that exist in the lives of young women are some of the heaviest obstacles to HIV prevention. The factors that make young female students vulnerable to HIV and AIDS are as follows:

a) *Structural Factors*

Access to health services is limited. Students can be reached fairly through HIV information, prevention, care and reproductive health promotion programs. Unequal access to health services, education, and the low status of women in society exacerbates vulnerability. Gender inequality and power relations limit girls' protection from HIV infection, and to seek care and support after being infected. Access to health care is important to improve quality of life. The ability to easily avail oneself to high quality care is likely to increase use of preventive services.

b) *Social Factors*

Poverty can be regarded as a threat to the wellbeing of women as it encourages behavior that increases the risk of HIV infection (Ackermann & de Klerk, 2002). Poverty is the major cause of HIV infection (Jackson, 2002). External environmental factors such as poverty and gender inequality are two significant factors in enhancing vulnerability to HIV infection (Msiska, 2003).

Gender inequality determines whether a person contracts HIV depending on the economic position, social class, or gender equality and equity. All these combine to create particular ways of making a living. Together these are the major influence on sexual networks (Barnett & Whiteside, 2002). HIV affects women and men differently in terms of vulnerability and risk impacts. Structural inequalities in the gender status of women make it harder for women to gain self protection. The women are kept in a subordinate position irrespective of age (Ackermann & de Klerk, 2002). Issues such as lack of respect, low status of women, sexual autonomy and gender autonomy prevent women from negotiating safer sexual practices (Ipinge et al., 2004).

c) *Cultural Factors*

The cultural norms that define men as superior to women make it difficult for women to protect themselves from HIV infection (Jackson, 2002). The disappearance of traditional values such as fidelity and abstinence are also contributing to the spread of HIV epidemic (Oguntibeju et al., 2003).

d) *Personal behavioral and sexual networking factors (Cohabitation, High Mobility, Peer Pressure, Concurrent and multiple sexual partnership, etc.)*

Multiple and concurrent partnerships contribute to the spread of HIV. A study conducted in Nigeria among college students revealed that a poor economy resulted in youth becoming involved in sexual networks, opting for multiple partners to earn a living (Chwee, Eke-Huber, Eaddy & Collins, 2007). According to Simbayi et al, (2005), several studies found that young females are at risk of sexual behavior that leads to increased opportunities for HIV infection. Cross-generational relationships increase the spread of HIV (Weissman et al., 2006). Some of the economic coping mechanisms used by young women include having a boyfriend to pay for basic necessities, but at the same time share sex with several partners in exchange for gifts (Ipinge et al. 2004).

e) *Biological Vulnerability*

Women are biologically more vulnerable to HIV infection (Ipinge et al., 2004; Oguntibeju et al., 2003). Physiologically, women appear to be at great risk of contracting HIV than men. Women are more susceptible to most sexually transmitted infections² including HIV infection because of the greater mucosal surface exposed to pathogens during sexual intercourse (Ipinge et al., 2004).

V. COMPREHENSIVE HIV/AIDS PREVENTION PROGRAMME (CHAPP): A DESCRIPTION

In line with the goals of the Nigeria National HIV Prevention Plan and Presidential Emergency Plan for AIDS Relief (PEPFAR) in averting new HIV infections through comprehensive HIV prevention programming, the project Revolt Against AIDS (RAA), implemented by Sound Health Development Initiative (SHIN)² whose physical presence is in Ado-Ekiti, takes an holistic and results-based approach to HIV/AIDS prevention using the engaging role-play model, learning-based model, campaign-based model, and support-based model. The Comprehensive HIV/AIDS Prevention Program (CHAPP) is an off-shoot of RAA and it is a collection of linked community-based activities that promote individual and community understanding of risk, shifts in behaviors and norms, and the adoption of a range of protective behaviors. It includes effective programming and referral links to other HIV/AIDS services and programs, as well as to other relevant services such as treatment for sexually-transmitted infections, sexual and reproductive health education, among others. The intervention project is embedded in a multi-level, multichannel approach targeting the tertiary institution communities as a whole.

a) *Project Goals*

- To reduce incidences of HIV and STIs in tertiary institutions.

- To reduce the feminization of HIV/AIDS in tertiary institutions.

b) *Objectives*

- Increase awareness, knowledge and skills level in HIV/AIDS and reproductive health.
- Increasing female student's capacity to reduce risk behaviour and vulnerability related to HIV/AIDS and STIs.
- Increase the capacity of female students to make good choices and informed decisions.
- Reduce exposure and vulnerability to HIV and STIs amongst the female students.
- Reduce stigmatization and to promote gender equality in tertiary institutions.
- To promote tolerance and openness when dealing with reproductive health issues.
- To promote healthy and sustainable livelihoods.
- To lobby for the rejuvenation of health service delivery at campus clinics.

VI. BENEFICIARY COMMUNITY AND PROJECT LOCATIONS

The project which was implemented in Ekiti State, relishes on the realization that the State has the lowest HIV prevalence rate in Nigeria as reported in the 2008 National HIV Sero-prevalence with HIV prevalence rate of 1%. The beneficiaries of the project intervention were female Students & lecturers/other educational employees in three tertiary institutions in Ekiti State, Nigeria. The project was implemented in the following three tertiary institutions in Ekiti State: Federal Polytechnic, Ado Ekiti, Ekiti State University, Ado Ekiti, and College of Education, Ikere Ekiti.

a) *Prevention Activities*

- Community Awareness Campaigns (Rallies)
- Specific population awareness campaign
- Community outreach
- Peer education model/peer education plus model
- Vulnerability issues
- Sporting events
- HIV/AIDS counselling and testing (HCT)
- Antiretroviral (ARVs)
- Provision of information centers
- Psychosocial support
- Anti-HIV Club

²Sound Health Development Initiative (SHIN) is a health and social well being non-governmental, non-profit making organization established in 2006 and registered in 2009 under the Corporate Affairs Commission, Nigeria.

The unique feature of CHAPP is the recognition that tertiary institutions do not always represent safe environments particularly for women and girls. Hence, gender was a critical factor with female students/staff participating in all the program aspects. In addition, all stakeholders were adequately mobilized to encourage networking, community ownership and personal relationships between the community representatives and the project implementers.

b) *Lessons Learned*

- Participation of staff and students is crucial in achieving the stated objectives of CHAPP as demonstrated during the Peer Education Training and a high turnout of staff during the mobilization of stakeholders. As a result of these, a partnership was formed between institutional structures which encourage periodic assessment.
- Involving women associations and religious groups (NAWACS, Daughters of Eve, FOMWAN, etc.) encouraged full participation and commitment.
- Situating program within the community context enabled community participation.

c) *Challenges*

- Lack of financial/Human resources: CHAPP was an off shoot of RAA project and as such the budget for it was limited.
- Lack of commitment from male lecturers

d) *Way Forward*

- Institutional leadership commitment, tertiary institutions HIV/AIDS policy, Anti-harassment policy and developing a gender perspective that recognises the greater vulnerability of women is highly recommended since they have crucial role to play in addressing the whole range of political, social, economic, legal and management implications of HIV/AIDs in higher education
- More organizations/Institutions may wish to replicate CHAPP.

ACKNOWLEDGEMENT

We acknowledge the U.S. Agency for International Development [USAID] for funding SHIN on RAA Project, The Association of Commonwealth Universities in collaboration with the Centre for Gender Studies-University of Kelaniya for organizing the Critical Women: Women as Agents of Change through Higher Education International Conference as well as funding my participation through the HIV/AIDS grant.

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