

Does Self-Perception of Risk of HIV Infection Make the Youth to Reduce Risky Behaviour and Seek Voluntary Counselling and Testing Services? A Case Study of Nigerian Youth

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KEYWORDS HIV; self-perception; VCT; Nigeria; youth

ABSTRACT The objective is to investigate whether self-perception of risk of HIV infection causes Nigerian youth to reduce risky sexual behaviour and to seek HIV testing. In this population-based qualitative study, indepth interviews were conducted among 90 undergraduates in three Nigerian universities. In each university, three focus group discussions were facilitated for males only, females only, and for both males and females (mixed). Results show that students with low self-perception of HIV infection felt they did not have a need for behavioural change or to do HIV testing. Those with high self-perception were not inclined to reduce risky behaviour or to seek voluntary counselling and testing. The conclusion is that self-perception of risk as a single factor is not enough to seek HIV testing.

INTRODUCTION

This study investigates the perceptions of Nigerian undergraduates of own exposure to infection with HIV virus on the basis of their sexual behaviour; the relationship between their self-perception of exposure to HIV infection and behavioural risk-reduction on the one hand; and the relationship between self-perception of exposure to HIV infection and seeking voluntary counselling and testing (VCT) services.

Nigeria is one of the countries with the largest number of people infected with HIV, with over 3.1 million adults in the age range of 15-49 years living with the virus (Federal Ministry of Health, FMOH 2001a) and a prevalence rate of 5.4 percent among antenatal clients in 1999 (FMOH, 2001b). It is known that among the general population, adolescents and youth are most vulnerable because it is within this age group that high-risk

behaviours are initiated (Banerjee and Baer, 2006). In Nigeria, the undergraduate period is a time when such high-risk behaviours are escalated, given that most of the undergraduates are within the youth age group (see Anugwom, no date: 592) or slightly older who are sexually more active than the general population. According to the Federal Ministry of Health (2001b), young people (to which most undergraduates belong) have the highest rate of HIV infection (8.1 percent in 1999).

However, the prevalence rate of HIV infection specifically among undergraduates in Nigeria remains unknown. The paucity of studies (data) on this is also evident in the case of perceptions of this group of people to own susceptibility to the risk of HIV infection in relation to their sexual practices (sexual risk behaviour) and in relation to seeking and utilization of voluntary counselling and testing services. Volitional sexual behaviour is of paramount importance in the transmission of HIV virus. Therefore, how a person views own vulnerability to getting infected with the virus is crucial in adopting sexual behaviour that will minimize the vulnerability (Ward et al, 1989; and Cochran and Peplau, 1989;

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cited in Anugwom, no date). It may also affect his seeking to know his HIV status through HIV testing. Knowledge of whether or not one is infected may in turn help to strengthen risk-averse or risk-reduction behaviour. In deed, it has been argued that this becomes more meaningful and more effective when people know their HIV status. Following this, voluntary counselling and testing has been defined as the 'process by which an individual undergoes confidential counselling to make informed choice about knowing his or her HIV status and to take appropriate action' (IPPF/UNFPA, 2004:1). In developed countries like Britain, such services have begun to attract utilization by target groups (McGarrigle, Mercer, Fenton, Copas, Evens and Johnson, 2005).

Among Nigerian youth, studies point to the fact that awareness of HIV/AIDS has not translated to behavioural change. For example, Adedimeji (2003) observes a 100 percent HIV/AIDS awareness rate among undergraduates in a Nigerian University, yet only five percent of his respondents reported using condoms during casual sexual intercourse with persons they were meeting for the first time. This observation becomes more worrisome when situated within the social practice of possession of multiple sexual partners among the youth in the universities. In one of the states in which our study took place, an earlier study reported that 77 percent of the study sample had initiated sex, and among them 27 percent had multiple sexual partners (Omoregie, 2003). Anugwom (no date) has similarly noted, with disappointment, that as much as 40 percent of his respondents who were also undergraduates did not care to protect themselves against being infected with HIV virus during sexual encounters. In deed, Anugwom observes condoms were used more for the purpose of avoiding pregnancies, and sexually transmitted infections (other than HIV) than for the purposes of avoiding HIV infection.

However, detailed explorations of why awareness has not matched behavioural change remains to be conducted. Why do educated youth who are supposed to know and to champion the course of HIV/AIDS education and enlightenment turn out to ignore the message? Could this attitude be related to their self-perception of risk of getting infected with the disease, since they already are aware that the disease exists (Adedimeji, 2003; Anugwom, no date)? How do

they perceive their susceptibility to being infected with the virus? What are the contextual social and economic factors that shape their adoption of behavioural change vis-à-vis their self-perception of exposure to the infection? How do they perceive and practise HIV testing (voluntary counselling and testing) in view of their self-perception of risk of infection? What contextual factors are important in mediating their attitude and practice of care seeking for HIV testing against the backdrop of their self-perception of risk of infection?

These questions were explored through qualitative methodological approach so as to provide an understanding of the lapses in the translation of awareness into positive behavioural change, which is important for the success of any interventions, approaches, policies and programmes geared towards HIV/AIDS prevention and control in Nigeria and other developing countries.

METHODOLOGY

Between May and November 2004 qualitative data were collected from undergraduates in three institutions of higher learning in Eastern Nigeria. The institutions include Institute of Management and Technology (IMT), University of Nigeria Enugu Campus (UNEC), both of which are in Enugu, Enugu State, and Abia State University (ABSU) in Uturu, Abia State. Thirty students were selected from each university for indepth interviews (IDI), with equal numbers of females and males. Each interview lasted for approximately one and a half hours. The interviews were based on interview guides prepared by the researchers. Three focus group discussions were conducted in each university: one for females only, one for males only and the third for both males and females (mixed). The focus group discussions lasted for two hours, and consisted of six students. Focus group discussions from the Institute of Management and Technology were designated FGD1; FGDs from University of Nigeria Enugu Campus were designated FGD2 and those from Abia State University FGD3. Focus groups for males, females and mixed were designated FGDa, FGDb and FGDC respectively. For example, FGD1a means focus group discussion from IMT for females only.

The selection of respondents for the indepth interviews and the focus groups was by the

snowball technique because sexuality is regarded as a private matter in this cultural environment, and people are generally unwilling to discuss their sexual life with outsiders. Therefore, snowball technique was applied to select those who were willing to discuss their sexuality with the researchers. Respondents who volunteered to participate in the study were assured of their confidentiality, and were told that pseudonyms would be used instead of their names in the cases of direct quotes.

The indepth interviews and focus group discussions were used to explore the sexual activities of the respondents, their usage of condoms, their self-perception of risk of HIV infection, whether self-perception was associated with reduction in risky sexual behaviour and whether self-perception caused them to seek HIV testing (voluntary counselling and testing).

Data analysis was started early in the course of the study. Individual interview scripts and FGD scripts were read over and over again. Codes were generated followed by the generation of themes. Memos were compiled based on the themes. Finally, cross-case analysis of the data was carried out.

RESULTS

Sociodemographic Characteristics: The average age of the respondents was 24 years, with the age range being 18 to 29 years. Equal numbers of females and males were maintained in the selection of study sample for both IDIs and FGDs. Among the respondents, 6.3 percent were from rural farming backgrounds, 22.6 percent had parents who were secondary school teachers/ head teachers/ lecturers, 41.5 percent were from families in graduate level middle civil servants/ self-employment, 11.3 percent had parents who were retired/ disengaged civil servants, 5.4 percent came from families of senior civil servants/ rich businessmen/ women, while the rest (13.9 percent) had parents belonging to 'other occupations', that is, petty traders and artisans, viz mechanics, carpenters, etc. These brief sociodemographic parameters will hopefully provide contextual information on the respondents which will aid in understanding and situating their responses.

Sexual Activity of Respondents: Since this is a study on sexual behaviour, it seems pertinent to provide information first on the sexual orien-

tation of the respondents. All the respondents who had initiated sexual intercourse stated that they were heterosexuals. Those who had not initiated sex reported that they were inclined to heterosexual relationships, and would practice heterosexual intercourse when they initiate sex.

The findings reveal a high level of sexual activity among the undergraduates. All the male respondents had initiated sexual intercourse. All the female respondents except two reported having initiated sexual intercourse (95.6 percent). Frequency of sexual intercourse and numbers of sexual partners of respondents in the four weeks prior to the study were explored. Within the period, 26 of the 45 males (57.8 percent) had sexual intercourse five to ten times, while 19 of the 45 females (44.2 percent) had sex five to ten times.

Table 1: Frequency of sexual intercourse among respondents in the four weeks preceding the study (percentages in brackets)

Frequency of intercourse	Males (N = 45)	Females (N = 43)
Nil	1 (2.2)	3 (6.9)
Once	2 (4.4)	1 (2.3)
2 – 4 times	9 (20.0)	7 (16.3)
5 – 10 times	26 (57.8)	19 (44.2)
More than 10 times	7 (15.6)	13 (30.2)

Source: Fieldwork (2004)

Thirteen of the 43 females who had initiated sex had had sex more than ten times within the same period (four weeks preceding the interviews) compared to seven of the males. Further analysis of the data shows that 11 of the 13 female respondents who had sexual intercourse more than 10 times in four weeks belonged to poor socio-economic background (parents were rural farmers, petty traders, artisans). By contrast, six of the seven males who had more than 10 episodes of sexual intercourse in the four weeks were from the higher socio-economic backgrounds.

The findings also show that there was a high propensity among the respondents to have multiple sexual partners. Approximately 69 percent of the males and 37 percent of the females had one to two sexual partners in the four weeks prior to interviews. Females were more likely to have more than two sexual partners compared to males (see Table 2). For example, 25.6 percent of the females had more than five sexual partners compared to 8.9 percent of the males.

The reasons for this paradox were explored

Table 2: Number of sexual partners among respondents in the four weeks preceding the study (percentages in brackets)

<i>No. of sexual partners</i>	<i>Males (N = 45)</i>	<i>Females (N = 43)</i>
Nil	1 (2.2)	3 (6.9)
1 - 2	31 (68.9)	16 (37.2)
3 - 5	9 (20.0)	13 (30.2)
More than 5	4 (8.9)	11 (25.6)

(Percentages may not add up to 100 due to rounding)

Source: Fieldwork (2004)

during the focus group discussions since males are traditionally regarded as more promiscuous than females and tend to have more sexual partners. The respondents stated that in terms of having one to two sexual partners, the males are more likely to keep two girlfriends at a time. This was referred to by the respondents as part of the usual 'campus life'. However, different reasons were given for the possession of three or more sexual partners. For the males, membership of campus confraternity groups (cults) plays a significant role. It is a display of machoism to belong to a cult and the members are said to perceive having many girlfriends as a mark of superiority of their members over other cult groups in the rivalry for the control of the social life on the campus. None of the respondents admitted to being a member of a cult. This is, however, not surprising since cult members usually swear an oath of secrecy of their membership, and since they also fear being expelled from the campus if they own up to cult membership.

Respondents in separate focus groups stated that having much money on the campus was also a factor in having multiple sexual partners among male students. They reasoned that in the face of economic hardship, it takes money to keep a girlfriend on the campus and much more money to keep more than one girlfriend.

'You cannot have a girlfriend on the campus if you don't have enough money. Your girlfriend will definitely ask you for financial help and if you cannot provide it, that may be the end of the relationship (Fidelis, FGD 1a).

'It is not every girl who demands money for friendship. However, a guy should assist his girl financially when needed' (Martha, FGD 1c).

'If you have much money on you as a guy, you will be able to meet the demands of girlfriends, if you so choose to have more than one. Keeping one girl is expensive, not to mention

keeping more than one. But with money you can keep as many as you wish. In fact, many of the girls don't care whether you have other girlfriends as long as you give them money' (Ephraim, FGD 3a).

'I have a boy friend but it is not for money. He does give me money from time to time.... He is a trader and not a student' (Monica, FGD 2c).

'There is nothing wrong with having a boyfriend who assists you with money. It does not mean that you sleep with him because of money' (Tosin, FGD 3c).

Findings from the indepth interviews suggest that economic and financial considerations play more important role for the female students than were evident from the FGDs. Female respondents were more open in their discussions on the role of money in their sexual behaviour. There seemed to be a consensus that having multiple sexual partners is a survival mechanism for many campus ladies.

Three respondents reported that they were willing to have casual sex with anybody who was willing and able to pay their price. A respondent from one of the institutions in Enugu indicated that she had regular clients and she usually went to hotels or to their homes to service her clients. In her words,

'My sister [referring to the female researcher], I must tell you the truth. I do it. I do it with men for money, with any man who is ready to pay me. What else do you want me to do? Every lecturer wants to sell their handouts and these are very expensive. If you don't buy the handouts they will fail you in spite of whatever you may write. I bought eight handouts this semester alone and they cost me 12,000 Naira [90.9 US Dollars]' (Ebere, 24 years, IDI, UNEC).

This position was similar to that of another respondent from IMT Enugu. She stated,

'The money I brought from home this semester was barely enough for my transport to reach school and for a few days after. Shouldn't I go to school? I must go to school no matter what it takes. I need money for books, accommodation, feeding and clothing, to say the least. Tell me where to get the money. I simply use what I have to get what I need. I am not ashamed at all' (Feeona, 28 years, IDI, IMT).

A female respondent from ABSU stated that undergraduate girls have multiple sexual partners than they would generally admit. She argued that the current economic hardship in Nigeria is such

that a large proportion of female students cannot meet their needs on the campus with the money got from their parents. To her, girls have more need for money than boys. The needs must be met, and neither the government nor the society cares about those needs. She stated that a man who had the means to assist a female undergraduate would rather not do so unless he had sex with her. Therefore, the girls have learnt to juggle their studies with some money-making by exchanging sex for cash.

When this issue was raised during the mixed male-and-female FGD at UNEC, all the participants felt that it was difficult to see how very many girls, if not most girls, on the campus would continue their academic pursuit without having financial support from males who were not their relatives and who would demand sex for the assistance. At the mixed FGD at ABSU, the participants were of the general opinion that the practice of girls having multiple sexual partners to aid them in their academic pursuit would only get worse. In the words of one of the participants, 'It has come to stay' (Ifeoma, FGD 3c).

Usage of Condoms

From a public health perspective, the findings of this study could be deemed worrisome in view of the low condom usage, which may suggest low level of reduction of risky behaviour. The condom usage by the respondents in this study stood at 12 percent for the males and five percent for the females.

In the male study group at IMT, the general opinion was that condom use was necessary for prevention of HIV infection. In deed, there was universal knowledge across all focus groups of the importance of condom usage as a means of preventing HIV infection. This was also the case for the IDI as all the IDI respondents were aware that condom usage could prevent HIV infection.

The public health issue then becomes translating awareness into concrete risk-reducing/ risk-averting sexual behaviour. Why would universal knowledge of HIV-protecting function of condoms translate to 12 percent and five percent condom usage for the males and females respectively?

Reasons identified during the FGDs include sheer lack of willingness to use condoms because it reduces pleasure; lack of money to buy condoms; lack of easy accessibility and

availability of condoms; and lack of bargaining power by females to insist on condom use during sex. Some of these reasons have also been observed in other studies. Anugwom (no date) reports that in addition to reduction of sexual pleasure, the respondents in his study cited condom breakage, partners suspicion, and ejaculation failure as some of the problems they encountered with condoms.

During the interviews, most of the respondents stated that they would like to use condoms but that condoms reduced sensation and pleasure; and this tallies with the findings from the FGDs on the reasons for low condom use. One respondent from ABSU stated that he had actually started using condom during his last sexual intercourse but he suddenly discarded it mid-way in the act because he desired to get the 'real feeling'. Most respondents agreed that males could use condoms if they would because their female partners would not object.

This contrasted with the situation for females, who though would wish to use condoms, frequently encountered objection and 'resistance' from their male partners. A participant at FGD 3c caused uproar of laughter during the FGD when she said to the male participants, 'You guys would not allow us to use condoms'.

On the relationship between the number of sexual partners and condom use, some of the male respondents who stated they had only one partner felt that there was mutual fidelity and so condom use was not necessary. Half of the females who indicated having only one sexual partner stated that they would, however, prefer to use condoms because condoms would also protect them from becoming pregnant.

Having multiple partners did not appear to be a critical factor in the decision to use condoms for female respondents. Respondents who reported having more than five partners in the four weeks preceding the study did not use condoms more frequently than those who indicated they had one or two partners. Indeed, female respondents who had more than five sexual partners and reported having sexual intercourse more than 10 times, paradoxically, indicated less condom use. They were also more likely to have sexual partners from outside the university community. By contrast, two of the four males who had more than five partners indicated condom use though inconsistently, and the other two reported consistent condom use.

The difference in the risky behaviour stems from differences in negotiating power based on money, and also on social construction of masculinity and femininity by which females are supposed to be submissive recipients in the act of sexual intercourse while the males are supposed to be the aggressive decision-makers. More importantly, in the absence of financial fall-back, female undergraduates succumb to the dictates of their (mostly) external (outside-the-campus) sexual partners. A female respondent in IMT said,

‘My priority is money for my studies. If he wants it without condom, he has it’
(Modesta, 25 years, IDI, IMT).

Another female student narrated how she lost out in a relationship because she had insisted on condom use and vowed not to repeat the ‘mistake’.

‘The man was very kind to me. He is a Bank Manager here in Enugu while his wife lives in Lagos. I spent my weekends in his house. He gave me any amount of money I needed. One day I read a pamphlet on HIV/AIDS, and when next he asked for sex, I insisted he must use condom. He said he would never do that. He broke our relationship. I suffered terribly from lack of money. So I went back to him to ask for forgiveness but he had already got another girl. I have learnt my lesson and would never make the same mistake again’

(Okwy, 28 years, IDI, UNEC).

It seems that in the face of harsh economic reality, fatalistic risky behaviour overcomes logic of self-protection from HIV infection. This does not only apply to the females, but also affects the males but in a different way. For example, though the males had the social power to use condoms, economic and financial constraints were also reported by them to negatively impact on their ability to use condoms. The costs of condom have been on the rise while their purchasing power has been on the decline. The males reported that when they had to choose between buying condoms and their own feeding on the campus, they usually opted for food, yet they did not abstain from sex.

Self-perception of the Risk of Infection and Screening for HIV

Respondents who reported having one to two partners stated that they were less likely to be

infected. Thirteen of the 90 IDI respondents (14.4 percent) felt that having sexual intercourse at all is a risk factor for everyone whether or not it is with only a sexual partner. The other respondents (85.6 percent) felt that HIV infection is a problem mainly for prostitutes and promiscuous persons. But how does their perception affect their seeking HIV testing? Out of 31 males who had one to two partners in four weeks, only two had ever had HIV screening. This amounts to 6.5 percent. Out of 16 females who professed having one to two partners in four weeks, only one respondent reported having ever done HIV testing (6.3 percent).

Probing into reasons for the low level of seeking HIV testing reveals that in addition to low self-perception of risk of infection among this group of respondents who had one to two partners, the costs of the HIV test might have inhibited them from utilizing the services.

‘It costs 1000 Naira (approximately 8 US Dollars) to do blood test for HIV in the laboratories in Enugu. That is the minimum you can get it. I even heard that it costs more than that in some laboratories. So, why would I spend that amount of money to find out if I am HIV positive or not’

(Emeka, 24 years, IDI, UNEC).

‘It costs too much for workers to do, not to mention students. I don’t think a student will go and spend a lot of money for the sake of knowing whether or not she has HIV infection’

(Magda, 25 years, IDI, ABSU).

‘If a doctor tells me to do the test if I go to a hospital to seek care, I will have no choice. But to go and spend my money for nothing in the name of knowing my status, count me out. After all, I am not sick and I am not planning a marriage soon’

(Peter, 27 years, IDI, IMT)

‘I am HIV negative and my mind is relaxed. I checked it two months ago. However, I did it because my church insisted my fiancé and I must do it before they would approve our wedding preparations. So my fiancé and I did and we are happy we did it. It cost us much money’

(Edith, 28 years, IDI, UNEC).

Among respondents who had *three to five* sexual partners, half of them professed they were at risk of HIV infection. However, only two female respondents reported they had undergone screening. No male respondent in this group had ever undergone HIV screening. Every respondent who had *more than five* sexual partners felt they

were highly at risk. But none of the male and female respondents in this category had done HIV screening, despite self-perception of being at high risk of infection.

Exploration of the reasons for low uptake of VCT among the respondents who professed high self-perception of being at (high) risk was done. The findings suggest that, as in the case of those with low self-perception, costs pose a significant barrier to accessing VCT services.

‘What I think about my status does not matter if I have no money to do testing. I am talking about feeding my self on the campus, testing can come later when I get enough money and by that time I should be getting ready to settle down [marry]. I know I might have exposed myself, but so what?’

(Okwy, 28 years, IDI, UNEC).

During the focus group discussions, financial cost was identified as the single most important factor impeding those who wish to do it. Otherwise, the participants at the various FGDs stated that it was usually when people were sick and went to the hospital and were required to do the test that they would part with money for the purpose of doing HIV screening. They also identified marriage as another reason for which people would do testing since most churches in Nigeria currently would insist on the test as a prerequisite for a couple to be wedded. However, for *voluntary* counselling and testing, cost remains problematic.

Participants also identified lack of awareness of the importance of the test, but most argued that awareness might not be enough to make people to do the test if the test remains costly. The participants were asked if they were aware of any special centre where free counselling and testing were done. The response indicated that the awareness of the availability of VCT centres was very low. They reported that they had heard of the existence of such centre through the radio and television but only three participants stated they knew the location of such centres though they were unaware whether the VCT services were free.

Fear of stigmatisation and discrimination were also stated by the IDI respondents and FGD participants as a reason for not seeking testing. One respondent summed it thus,

‘Even if I am already infected, nobody knows and it causes me no problems, at least for now. Imagine I go and do the testing and I find out I

am positive, for how long will I hide it? Once people get to know I will be finished. My family will shun me. My friends will desert me. I will not be able to get a decent job. That is dying even before the infection kills me’

(Maria, 25 years, IDI, ABSU).

DISCUSSION

The findings from this study have serious implications for public health and HIV/AIDS prevention and control in Sub-Saharan Africa and possibly other developing Countries. There is a high level of sexual activity among the respondents, with a high propensity to have multiple sexual partners. The relationship between self-perception of HIV infection and risky sexual behaviour is also a source of worry. It is observed that people who have single partners felt that they were not much at risk and so did not need to use condom, while those who have higher numbers of partners felt they were at risk but yet were not prone to using condoms for various reasons. Adedimeji (2003) reports a similar finding among undergraduates of the University of Ibadan in Southwestern Nigeria where only 20 percent of sexually active respondents professed that they were at risk of getting infected. Interestingly, 75 percent of the respondents in his study felt that they were invincible to HIV infection. Consequently, majority of the respondents did not consider reduction of risky behaviour as essential. Although the respondents in our study did not feel invincible to the infection, there was minimal adoption of behavioural strategies to reduce the risk of infection. Therefore, in both cases (studies), the endpoint, which is the possibility of unremitting transmission of HIV virus, portends danger in the fight against HIV/AIDS. People who have single partners may actually change sexual partners though they may have one at a time. In this way, they may carry infection from their old partner to the new one or may themselves be the source of infection to the consecutive partners. This is also problematic since they do not go for HIV screening because of their low self-perception of risk of HIV infection. Public health education must aim at creating awareness among those who have low self-perception of risk on the necessity of adoption of safer sex and on the benefits of knowing their HIV status.

The finding that *high* self-perception of risk does not lead to reduction of risky behaviour through adoption of safer sex practices is also worrisome. If those who have concurrent multiple sexual partners do not correctly and consistently use condoms, the rate of transmission of HIV virus among the partners will probably be faster, creating a 'chain reaction' of HIV transmission as each partner may get another sexual partner who was initially not a member of the 'ring'. The study findings reveal that respondents who professed having multiple sexual partners and expressed *high* self-perception of risk *least* utilized HIV testing services. In another study among the youth in the United States (Banerjee and Baer, 2006), as high as 89 percent of respondents who professed high or very high self-perception of risk of infection did not undergo HIV testing. In the study, gender-segregated analysis reveals that females had lower self-perception of risk of infection than males yet their rate of HIV testing was almost three times that of males. Our study, being an exploratory qualitative research was not subject to testing for statistically significant differences based on gender. However, indepth exploration of gender-based contextual cultural, economic and social factors that underpin sexual behavioural differences versus attitude toward HIV testing was done. The study observes that social construction of feminine and masculine (often double standard) roles in volitional sexual encounter provides a social milieu which accentuates the vulnerability of females to HIV infection. Equally contributing significantly to this is women's lack of economic power, which attenuates their bargaining power in sexual negotiations, yet renders them prone to indulging in transactional sex due to their economic dependency state.

Therefore, appropriate and effective interventions should seek to tackle lack of/inadequate translation of awareness into concrete and effective behavioural change through vigorous public health education and developmental problems such as economic empowerment of women. There should also be provision of free, cheap and easily available condoms, and provision of free or cheap and easily available VCT services. In addition, there is a need for policy makers and implementers to put in place structures and institutions that will cater for those who get tested and are HIV positive. Such

structures and institutions should seek to eliminate stigmatisation and discrimination against HIV positive people, while at the same time ensure provision of free anti-retroviral drugs, adequate support and care for them.

CONCLUSION

The findings reveal that respondents who had one or two sexual partners had low self-perception of risk of getting infected with HIV virus, despite the fact that they might later change the partners. This low self-perception of risk is also associated with the tendency to ignore safer sex (condom use) as a risk-reduction measure, and with the tendency not to seek VCT services. Respondents who had multiple sexual partners (more than two) had high self-perception of risk of HIV infection. But this neither led them to adopt risk-reduction measures against HIV infection nor increased their tendency to seek VCT services.

Therefore, self-perception as a single factor is not enough to utilize VCT services. Economic and financial constraints, gender issues, fear of stigmatisation and discrimination are also important factors and may actually attenuate any effects of self-perception on seeking VCT services. Policy planners and implementers need to take these factors into explicit consideration when designing interventions.

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