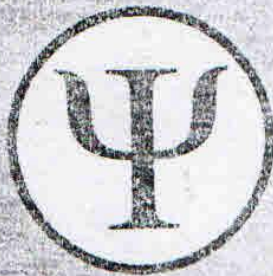


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PREVENTION OF HIV/AIDS AS PERCEIVED BY RELIGIOUS LEADERS IN ILORIN METROPOLIS, NIGERIA

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Abstract

HIV/AIDS, which was discovered in 1981, has remained the highest killer infection that the world is struggling to overcome. In the first one and a half decades of its appearance, the infection successfully affected over 40 million people while more than 20 million deaths were recorded resulting from AIDS-related diseases. Nigeria has been identified as HIV/AIDS endemic country. Interestingly, HIV/AIDS which is a life-long disease with no specific vaccine for its prevention is quite preventable through multi-dimensional approach. This study therefore focused on investigating the perception of religious leaders on prevention of HIV/AIDS. A sample size of 300 participants was purposively selected in Ilorin metropolis to respond to questionnaire items. Responses from the participants were analysed using the analysis of variance (ANOVA) statistical measure. Results indicated that religious leaders perceived HIV/AIDS as being preventable through well adjusted sexual behaviour. It was also discovered that perceptions of respondents were different based on religious affiliation, age and educational qualifications. It is therefore recommended that religious leaders should be actively involved in the HIV/AIDS campaign programme. Equally, counsellors should work closely with religious leaders in ensuring change in sexual behaviour of people.

Key words: Prevention, HIV/AIDS, Religious Leaders

Introduction

The Acquired Immuno-Deficiency Syndrome (AIDS) which was first discovered in the United State of America in 1981, has since over two decades remained the world's most powerful and undefeated epidemic that claims lives everyday. The rate at which the infection (HIV) and the subsequent condition (AIDS) have devastated the hope of many countries can not be quantified. Considering the consequences of HIV/AIDS around the globe, Ajiboye (2006) described the situation as the greatest plaque the world has ever known. The Human Immuno-deficiency Virus (HIV) is the only identified cause of AIDS. The

virus has the potential of destroying the body defense system and thus exposing the victim to chains of opportunistic infections. Thus, HIV does not really kill but constructs a smooth road to death. It is after the body's immunity has been destroyed that one becomes inescapable to various diseases which eventually lead to death. According to the World Health Organisation (WHO, 2002) being HIV positive or having HIV disease is not the same as having AIDS. This is because many people are HIV-positive but do not get sick for many years. Although HIV has been identified as a deadly and incurable infection, it is still not known how many out of the seropositive persons will develop AIDS since the progression of HIV destruction to the body's immunity is dependent on the strength of an individual's antibodies. The individuals whose HIV-positive status would never develop to AIDS are referred to as Long -Term - Non - Progressors.

Transmission of HIV

The genesis of HIV/AIDS has remained controversial. While some quarters submitted that human accessed the virus from the green monkeys, others blamed it on the carelessness of the United States' nuclear weapon technology where some doses of toxic materials were released and became HIV. Many others equally traced the origin of the pandemic to the genocidal scheme of the ousted apartheid government of Southern Africa. So cloudy the history of HIV could be yet its mode of transmission is clearer (Ajiboye, 2006). The Centre for Disease Control (CDC, 2008) identified various ways by which HIV is transmitted. These include sexual intercourse, by sharing skin piercing objects with infected persons, through blood transfusions and mother-to-child infection. However, Ajiboye (2006) categorized all the various ways by which HIV is transmitted into two viz: **biological and mechanical**.

The biological modes include the mother-to-child (MTC), especially while the baby is unborn. The blood of HIV seropositive mother and the foetus get in contact through the placenta, thus infecting the child. The International Planned Parenthood Federation (IPPF, 1998) revealed that a small number of HIV do exist in the breast milk of an infected mother, which may predispose the child to equal infection. HIV transmission has been largely traced to sexual intercourse through the penetration and deposit of HIV infected sperm into the vaginal barrel and penetration of infected vaginal fluid into the penis. In whichever way, they are both biological.

On the other hand, the mechanical is any form of HIV transmission that involves skin piercing such as cuts, incision and bruise. The act of sexual intercourse may bring tears and bruises to the vagina and the penis in which there could be blood contact. Equally the process of blood transfusion, bite by the baby while sucking breast, incisions on the body and any other forms of exercise that opens up the skin, leading to blood contact, are regarded as mechanical modes of HIV transmission.

Epidemiology of HIV/AIDS

The global epidemiology of HIV/AIDS pandemic reveals its presence across various continents of the world. In Cambodia 2.7% of the population were infected with HIV in 2003 (Footsteps, 2004). In Botswana, Namibia, Swaziland and Zimbabwe, estimates indicate that between 20% and 26% of people aged 15-49 are living with HIV/AIDS (UNAIDS, 2002). According to the National HIV sero-prevalence Sentinel Survey (2003), Nigeria has a prevalence rate of 5.8% as at 2003 and a projection of 5.2% in 2008 which indicates a negligible decrease. It was also projected that Nigeria will record cumulative deaths of 4.2 million, resorting from AIDS by the year 2008, (Federal Ministry of Health, 2004). The trend portends a great calamity for the country. Kwara State for instance, has a prevalence rate of 2.7% while Ilorin was identified as having the highest HIV prevalence rate of 3.0% in the State (FMOH, 2004).

Psychosocial Effects of HIV/AIDS

The HIV infection carries its multiple consequences on the life of the patients. However, apart from the health condition which predisposes the victim to discomfort, the financial cost of managing AIDS is equally enormous. Reports (UNAIDS, 2003, Gateway, 2008) revealed that stigmatization has become the major problems faced by the people living with HIV/AIDS (PLWHA). From the moment scientists discovered HIV and AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination and stigmatisation have spread rapidly, fuelling anxiety and prejudice against the group most affected, as well as PLWHA. In this case, stigma is a powerful tool of social control. It has been used to marginalize, exclude and exercise power over individuals who show certain characteristics of being infected.

Stigmatisation and discrimination against PLWHA are common place in Nigeria because both Christians and Muslims see immoral behaviour as being the cause of the HIV/AIDS epidemic. This affects attitudes towards HIV seropositive individuals. PLWHA often lose their jobs, are denied health care and are isolated and threatened. In some societies, laws, rules and policies can increase the stigmatization of PLWHA. Such legislation may include compulsory screening and testing, as well as limitations on international travel and migration. These further the stigmatization with its attendant psychological effects on the victims (Gateway, 2008).

Stigma can be expressed at the instrumental and symbolic levels. It is considered instrumental when individual expresses concern about the risks of contracting HIV through casual contact with PLWHA. Symbolic stigma is a vehicle for expressing religious, political, or other attitudes and values through one's perception of PLWHA (The Body, 2008). The concern here is the effects of various conditions of an HIV-positive individual, which range from anxiety, depression, stress even to neurosis and psychosis.

Statement of the Problem

The first case of AIDS was identified in Nigeria in 1986 and HIV prevalence rose from 1.8% in 1988 to 5.8% in 2003. Statistics (FMOH, 2004) show that the number of people living with HIV/AIDS (PLWHA) as at 2003 was between 3.2 and 3.8 million while over 2 million AIDS-related deaths have been recorded. The 2003 National HIV Sero-prevalence Sentinel survey projected a cumulative death of 4.2 million from AIDS by the end of 2008. The HIV/AIDS epidemic is still at an alarming rate because the human toll of AIDS has become a tragic reality experienced by families, communities and the nation at large, reducing the productive workforce and National economic growth.

Notable people in Nigeria have advocated a multi-dimensional approach to the prevention of HIV/AIDS. The former Nigerian President, Olusegun Obasanjo, advocated for the involvement of faith-based organizations in combating the spread of HIV (Garland, 2003).

According to McCain (2003), dignitaries such as Alhaji Maccido (the late Sultan of Sokoto), Pastor E.A. Adeboye (General Overseer, Redeemed Christian Church of God), Prof. Oshotimehin (the Former Chairman, NACA) and other members of the society have advocated for consideration of religious perspective in fighting HIV/AIDS pandemic. Ajiboye (2002) reported that Faith Based Organisations (FBOs) were successfully used to stem the tide of increasing rate of HIV/AIDS in countries such as Kenya, Zimbabwe, India and other AIDS ridden spots. In Nigeria, Ilorin metropolis is notably identified with the practice of Islam and thus tagged the *city of Islamic Scholars* (Ilu Alfa). Equally Christianity is largely practiced all over the city while the state secretariat of Herbalist Association (predominantly traditional worshippers) is situated in Ilorin metropolis. The positions and response of religious leaders in Ilorin would reliably represent the perception of other religious leaders on prevention of HIV/AIDS.

Research Hypotheses

1. There is no significant difference in the perception of religious leaders in Ilorin metropolis on the prevention of HIV/AIDS on the basis of religious affiliation.
2. There is no significant difference in the perception of religious leaders in Ilorin metropolis on prevention of HIV/AIDS on the basis of age.
3. There is no significant difference in the perception of religious leaders in Ilorin metropolis on the prevention of HIV/AIDS on the basis of education qualifications.

Method

Descriptive survey design was used for the study. The study consists of 300 sampled representatives. The participants were purposively selected

from the three main religions in Nigeria (African Traditional Religion, Christianity and Islam). The cluster sample technique was used to select the respondents in the areas where each of the religions is predominant. Equally the stratified random sampling was used to select participants in respect of their educational qualifications, age and religious affiliation.

The measuring instrument used for the study was a questionnaire tagged "Perception on the prevention of HIV/AIDS". It consists of two sections (A and B). Section A sought demographic information such as age, religious affiliation, and educational qualifications. Section B consists of 12 items on prevention of HIV/AIDS. The items were patterned after the 4 - point Likert-type rating scale. The reliability index of the instrument was 0.71 which was determined by using the test-retest method.

The instrument was physically administered to the respondents by the researcher with assistance from some *ad hoc* personnel who were specifically trained for the purpose. Three hundred questionnaire forms were distributed and all were returned after being correctly completed. The analysis of variance (ANOVA) statistical method was used to test the three hypotheses postulated for the study at 0.05 alpha level of significance while the Duncan Multiple Range Test was adopted to determine the direction of significant difference.

Result

Table 1: Means and rank orders of respondents' perception on prevention of HIV/AIDS

ITEM NO.	ITEM	Mean score	Rank
	In my own view, HIV/AIDS could be prevented if:		
1	couples remain faithful to each other	3.07	1 st
3	people abstain from sex before marriage	3.06	2 nd
2	commercial sex work is eradicated	3.01	3 rd
6	there is religious teaching against pre-marital sex	2.89	4 th
9	there is constant teaching on consequences of extra marital sex	2.72	5 th
7	illicit sexual activities are stopped	2.66	6 th
4	adequate emphasis is placed on sex education	2.56	7 th
10	people avoid multiple sex partners	2.53	8 th
14	Sterilized skin piercing objects are used	2.53	9 th
11	blood contact of any form is avoided	2.51	10 th
5	condom is made free for users	2.49	11 th
15	protective sex is encouraged	2.47	12 th
8	blood screening is conducted before transfusion	2.41	13 th
13	people use condom always during sexual intercourse	2.31	14 th
12	Religions leaders emphasis the use of condom in religious message	2.29	15 th

Prevention of HIV/AIDS

Table 1 revealed those items, 1, 3, 2, 6, and 9 ranked 1st, 2nd, 3rd, 4th and 5th. The perception of religious leaders indicates that HIV/AIDS could be prevented through the control of sexual behaviour. On the other hand, item 12, which suggests the use of condom ranked last.

Table 2: ANOVA Result comparing the respondents' perception of prevention of HIV/AIDS on the basis of religious affiliation

Source	df	Sum of squares	Mean square	F-cal	F-ratio	P
Between groups	2	5531.81	2765.93	8.18*	3.00	2
Within Groups	297	8367.10	28.16			
Total	299	14898.91				

*Significant, $p < 0.05$

The result of the ANOVA in Table 2 revealed that the F-calculated (8.18) is greater than the critical F-ratio (3.00). Therefore, the null hypothesis which states that there is no significant difference in respect of religious affiliation, is rejected, $F (df= 2 \text{ \& } 297) = 8.18, p < 0.05$ difference in respect of religious affiliation, is rejected; $F (df = 2 \text{ \& } 297) = 8.18, p < 0.05$.

Table 3: Duncan Multiple Rang Test (DMRT) showing the direction of significant difference

3	Islam	44.73	120
2	Christianity	44.73	120
1	African Traditional Religion (ATR)	36.31	60

The result of the DMRT indicated that group 3, which has a mean score of 44.73, significantly differed from groups 2 and 1 with close means of 36.77 and 36.31 respectively.

Table 4: ANOVA Result comparing the respondents' perception of prevention of HIV/AIDS on the basis of age

Source	Df	Sum of squares	Mean square	F-cal	F-ratio
Between groups	2	696.47	348.24	7.83*	3.00
Within Groups	297	13202.44	33.45		
Total	299	14898.91			

*Significant, $p < 0.05$

The analysis from Table 4 showed that the calculated F-value (7.83) is greater than the critical F-ratio (3.00). It revealed that the null hypothesis, which states that there is no significant difference in respect of age, is rejected, F

(df=2 & 297) = 7.83, $p < 0.05$.

Table 5: DMRT showing the direction of significant difference

Group	Value	X	Count
1	2- - 35 years old	40.82	105
2	36 - 50 years old	39.87	129
3	51 years old and above	36.76	60

The result of the DMRT indicated that group 3, with a means score of 36.76, differed significantly from groups 1 and 2 that have means of 40.82 and 39.87 respectively.

Table 6: ANOVA Result comparing the respondents' perception of prevention of HIV/AIDS on the basis of Educational qualifications

Source	Df	Sum of squares	X	F-cal	F-ratio
Between groups	2	533.78	266.89	6.09*	3.00
Within Groups	297	13015.21	43.82		
Total	299	13548.99			

*Significant, $p < 0.05$

Table 6 revealed the result of the ANOVA statistical method. The result showed that the calculated F-value (6.09) is greater than the critical F-ratio (3.00). Hence, the null hypothesis, which states that there is no significant difference in respect of educational qualifications, is rejected; F (df=2 & 297) = 6.09, $p < 0.05$.

Table 7: DMRT showing the direction significant different

Group	Value	X	Count
1	Prim, sec sch cert and equivalence	41.07	83
2	OND, NCE and equivalence	38.50	146
3	First degree, HMD and above	37.59	71

The result of the DMRT indicated that group 1, which has a mean of 41.07 significantly differed from groups 2 and 3 with mean scores of 38.50 and 37.59 respectively.

Discussion

The results on items ranking revealed that positive change in sexual behaviour was the major strategy for preventing HIV/AIDS as perceived by religious leader. Hence, one may not be surprised if abstinence from sex forms the central message of campaign against HIV/AIDS in religious circles.

The result of the test used on the first hypothesis confirmed that

significant difference exists on the basis of religious affiliation. This was not unexpected. Basically, there is variation in the beliefs, doctrines and practices of the three religions; on account of this, the perceptions of the religious leaders from different faiths could not be expected to be the same. The study of Ajiboye (2002) equally established that attitude of religious leaders towards family planning was significantly different on the basis of religious affiliation.

The second null hypothesis which states that there is no significant difference in respect of age was rejected. The explanation for such outcome is that, the view and perception of individuals of different ages vary because of maturity and experiences. Age plays significant roles in human personality development. The ability to acquire knowledge and in what capacity is dependent on the age of maturity, hence, tendency for variation in perceptions.

The analysis in Table 5 revealed the result of ANOVA. The null hypothesis which states that there is no significant difference in respect of educational qualifications was rejected. The reason for this result could be the fact that individuals from different levels of educational background may be influenced by their knowledge at various stages of educational training. The difference in educational backgrounds of the respondents did expose them to different views and perceptions about issues, especially those that require adequate information.

Counselling Implications

The findings in this study have some implications for counselling. It is important for counsellors to give orientation to religious leaders about modern methods of therapy, especially to people living with HIV/AIDS. Information is an integral part of counselling, it is therefore paramount for counsellors to organize seminars for various faith based organizations on different aspects of the HIV/AIDS pandemic. Although religions place much emphasis on sexual behaviour, other behaviours that put people at risk should be explained to religious adherents.

Religion has a solid grip on people's attitude to phenomena. In that wise, counsellors may partner with religious leaders in reaching the society through religious programmes. This could be done by facilitating HIV/AIDS campaigns in religious centres. The success of the effort to prevent the spread of HIV/AIDS is dependent on effective counselling interventions. Hence, if the present programme of capacity building is to succeed, concerted efforts must be geared toward reducing the rate of HIV prevalence. Counsellors are endowed with the required skills to help combat stigmatization and discrimination. However, counsellors should consider factors such as age, educational qualifications and difference in religious affiliation while working with faith-based organizations because such variables may create variations in the perception and attitude of the audience.

Recommendations

On the basis of the results of this study the following recommendations are being made:

- Counselling psychologists should consider networking with various religious organizations in order to find solution to the lingering problems associated with HIV/AIDS pandemic. It is important to consider the view of people from religious perspective for better understanding. By so doing ideas may be cross fertilized to produce effective intervention strategy.
- Government, civil societies, including Faith Based Organisations (FBOs) should partner and strategise on how to prevent the spread of HIV/AIDS. The ongoing efforts to completely wipeout HIV/AIDS through prevention could be better achieved if the scheme is embraced by the organized civil society. The CSOs (Civil Society Organisations) in onjunction with government may organize seminars, workshops, advocacy etc. tailored toward the set goals.
- Counselling psychologists and F.B.Os should be actively involved in fighting stigmatization and discrimination against PLWHA. The counsellor should educate the F.B.Os on modern scientific techniques to interact with HIV/AIDS patients appropriately. The counsellor should take advantage of religious gatherings to teach life building skills*such as assertiveness, interpersonal relationship, decision-making etc.

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