Factors that have led to increased HIV/AIDS Prevalence among Adolescents aged 13-21 Years in Hoima Regional Referral Hospital, Hoima District. A Cross-Sectional Study.

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Abstract

Background:
The study broad objective was to determine the factors influencing increasing prevalence of HIV/ AIDS among adolescents to suggest relevant and appropriate interventions that may be applied in the future in order to decrease the prevalence and combat HIV/ AIDS.

Methodology:
A cross-sectional study was carried out at Hoima Regional Referral Hospital to determine the factors which have influenced HIV/AIDS prevalence among adolescents from 12th March 2013 to 18th March 2013. Data was collected from adolescents who attended for OPD services and it involved interviewing the adolescents using questionnaire by the researcher on the demographics, HIV related knowledge, awareness, and attitudes on preventive measures and social factors that influence increase in HIV prevalence. The data was analyzed manually using a scientific calculator and was compiled in form of tables, pie charts and bar graphs

Results:
Unplanned sex (35%), Beautiful partners (22%), influence of partners (4%), presence of AVRs(10%), and Fear to buy condoms(29%), were the factor that have led to the increased HIV/AIDS amongst adolescents.

Conclusion :
The involvement of other sectors of community like local councils, learning institutions, churches, civil society organizations and NGOs will do a long way in promoting effective knowledge to the adolescents about HIV preventive measures.

Recommendations :[a]
The government through the ministry of health should continue to sensitize adolescents through health education about ABC strategies and safe male circumcision importance in an effort to combat HIV new infections.

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1 Background of the study problem

Uganda's scaling back of HIV infections from double digits in the early 1990s to single digits in the

early 2000s made the country a global brand in best practices to tame the scourge. More funds and expertise poured into the country and efforts were made to replicate the country's ABC model in other countries. It is projected that unless significant changes in behavior and attitudes occur, prevalence will continue to rise.

The impact of the epidemic on the fabric of life in Uganda is far-reaching. For instance, cumulative number of deaths due to AIDS stands at 900,000 people leaving an estimated 1,763,000 orphaned children aged between 1-17 years in the country (UAC NEWS, 2012).

AIDS has compromised all the productive sectors in Uganda. Agricultural growth has been affected by reduced labor supply, with negative impacts on overall economic growth and inequality.

The health sector has been overwhelmed by numbers; 50-70 of medical admissions are related to HIV.

But the global poster child for containing the virus is now on the spot for the opposite reason Uganda is now the only country in sub-Saharan Africa, besides Chad, where infections are going up and not down. The last seven years have seen the rise in infection by a full percentage point. The country is now, like many others in Africa, is toiling on many fronts to meet the enormous demand for HIV services.

Currently, over one million people are infected with HIV, 6.4% of all adults aged 15-49 years. Its transmissions of knowledge are all compromised (UAC NEWS, 2012).

Various efforts have been made to prevent further spread of HIV. The country has various policies and Protocols to support the VCT including routine counseling and testing and PMTCT programs and a rapid expansion of the sites.

Consequently, access to services continues to improve although there still exits a big room for improvement, particularly access to testing and prevention (UAC NEWS, 2012). Despite of all the government and WHO efforts in HIV prevention, high prevalence still recognized among the adolescents.

HIV/AIDS has been a serious problem since 1982 when it was discovered in Uganda. Globally, by 1993, January more than 60,000 AIDS cases were reported (UNAIDS, 2010). It also estimated that where there is under diagnosis and reporting delay, more than 2.5 million cases have occurred. WHO projections of HIV/ AIDS by 2000, based on the data 1993 in that there were 40 million cumulative adult HIV infections. 95% of the 40 million HIV infected people worldwide do not know they are infected. In Uganda less than 20% of the population has tested for HIV.

Although the youth are the hardest hit group by this disease, there level of uptake of these services especially counseling and testing services in the country is dispiritingly low yet knowing one's status is widely acknowledged as a key entry point to HIV I AIDS prevention and care services. Unless HIV testing and counseling to know everyone sero-status is exercised, prevention will still be limited.

Innovative solutions must be found to dramatically increase the number of individuals who are tested and know their status as well as development, implementation, and evaluation of new, highly efficient and effective models. There exists a huge gap in the Scaling up of current counseling and testing services (UNAIDS, 2010).

In Africa the HIV/AIDS cases keep on increasing as compared to other continents like Asia, in 1993, Africa was 33.3% and Asia was 1%, in 2011, Africa was 68% Asia is 6%. Countries of South Africa have some of the highest HIV/AIDS prevalence rate in the world and in addition to the above HIV/AIDS prevalence in 2002, was 1.2 worldwide, 0.6 in North America, but it was 9.0 in sub Saharan region (Prb.org.articles, 2002).

In Uganda, for every one the ministry of health puts on treatment, three new infections occur making it a universal task. The epidemic is mainly transmitted through hetero-sexual intercourse followed by mother to child HIV transmission which is a consequence of parental sexual behavior. It is driven by complacency in sexual behavior manifested in multiple concurrent sexual partnerships & transactional sex.

Currently, there is an increasing HIV/AIDS prevalence despite the WHO and government's efforts of reducing HIV/AIDS case, through provision of condoms, health education in high schools & enlighten people about proper use of condoms & other supplies in clinics i.e. 105,000 in 2007, 110,000 in 2008, 124,000 in 2009, 129,000 in 2010 translated into 353 new infections daily in 2010. There were 64000 estimated AIDS related deaths in 2010 translating into 175 deaths per day which is very worrying but the factors that have influenced this gradual in-

crease in adolescents has not been clearly brought to desk (UAC NEWS, 2012).

STUDY METHODOLOGY

Study area

The study was conducted in Hoima Regional Referral Hospital (HRRH) in Hoima Municipality Hoi ma district found in Bunyoro Kitara Kingdom in mid-western Uganda Hoima district is located 225km northwest of Kampala with a population 428,500 people and a growth rate of 2.8% annually (UBOS estimate, 2010). Hoima town has a population of 42,600 (estimate 2011). Hoima district is headed by the chairperson local council V but administratively by a Chief Administrative Officer (C.A.0). Hoima Regional Referral Hospital is a public hospital administered by the ministry of Health and attending to all referred patients from the surrounding districts. It is headed by the Medical Director assisted by an Administrator. The Hospital is located in the south of Hoima Booma ground and east of Hoima Police Station. The Hospital has laboratory departments of out and inpatients. Inpatients department is made up of wards in which patients severely sick are admitted and managed The wards available include Medical comprised of male and female wards, Pediatrics, Gynecology, ophthalmology, Emergency, Tuberculosis, Surgery, and Psychiatry; maternity and Labor wards making it most complex department. The out patients majorly visit O.P.D, Dental, Antenatal, X-ray, Ear, Nose and Throat, and ART departments.

Study Design

The study was a cross-sectional. The design was used-to determine the factors that have led to increasing HIV/AIDS prevalence in adolescents.

Study population

The study involved outpatient clients at Hoima Regional Referral Hospital (HRRH) who were aged between 13 and 22 years

Study Variables

The questionnaire was used to seek information on respondent's characteristics, age in years, sex, and religion, education levels, social factors influencing HIV, knowledge, attitudes and practices towards HIV preventive measures.

Study tools

The study tool used was a questionnaire which was designed by the researcher basing on the objectives and collected information about the knowledge, attitudes and practices towards HIV preventive measures and social factors contributing to the increase in HIV/AIDS prevalence. The questionnaire consisted of both closed and open-ended questions. The research was designed by the researcher and was approved by school research committee which issued the researcher with an introductory letter for carrying out the research in the study area.

Sampling flame

This involved all adolescents who came in Hoima Regional Referral Hospital (HRRH) from 12th March 2013 to 18th March 2013.

Sampling size estimation

This was determined using formula (Burton Et a11964 sampling size estimation), and a total of 100 participants were selected.

Sampling procedure

The youths were interviewed until 100 respondents of age range (13-21) years were achieved without repetition using simple random sampling.

Pilot Study

The questionnaire developed by the researcher was pretested among youths at Medicare Health Professional College. The purpose of pretesting was to take and correct errors and identify possible problems likely to be met during data collection. This was done to know whether the respondents could easily understand and answer the questionnaire as desired and necessary corrections were made before the actual data collection process.

Data collection

5 days were used in collection until 100 respondents were achieved. The hospital administration granted ethical approval for the study prior to the start of the process.

2 Data analysis

The researcher analyzed the data manually by tallying them arranged the data for presentation after collection and analysis

Data presentation

After data analysis, the data was presented in frequency tables, percentages, bar graphs and pie charts.

Quality control

During the interview, the language which was known to the respondents was used and a pretested questionnaire was used. Random sampling methods were highly maintained and followed up to ensure that data collection went on smoothly.

Study limitations

There were inadequate resources like funds, some respondents were not cooperative and some first asked for bribery before answering any questions, others refused completely to answer while others respondents pretended to know nothing

Ethical consideration

The proposal was approved by the research committee of Medicare Health Professionals College which gave the researcher an introductory letter to the District Health Officer (DHO), Hoima district.

The respondents participated in the study by consenting with a signature. Data was collected using a pre-tested questionnaire and was self-administered to the respondents. Data. was stored with a high degree of confidentiality.

Dissemination of data

A copy of the research project report will be sent to Uganda Allied Health Examination Board (UAHEB), office of District Health Officer (DHO) Hoima district and Medicare Health

Professionals College. Results got will be available for mass media people, and other researchers who will use it for literature review.

Results

Demographic data.

This table 1, shows that adolescents interviewed with age group of 13-15 years were 16(16%), 16-18years were 52(52%) and 19-21 years were 32 (32%). Most of the adolescents were in the age group of 16-18years 52(52%)

Figure 2: Distribution of respondents by their marital status (n=100)

Majority of the respondents were singles 86(86%), followed by married ones 10(10%) and the least were widowers with 4(4%).

Shows that most respondents were protestants with 42(42%), followed by Catholics 30(30%), Muslims 16(16%), born again 10(10%) and seventh day Adventists 2(2%) with the least respondents.

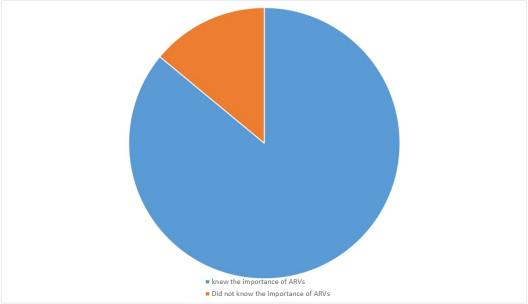
Figure 3: Distribution of respondents by their level of education (n=100).

shows that among respondents, students were highly represented by 86(86%), both businessmen and women and civil servants were represented least with 6(6%).

2.1 Knowledge about/AIDS

Figure 3: Distribution of respondents who knew about HIV/AIDS ways of transmission (n=100).

Figure 4: Distribution of respondents who knew about importance ARVs. (n=100)



The figure 4 shows that most of the respondents knew very well the importance of ARVs 86(86%), while 14(14%) did not know very well the main importance of ARVs.

2.2 Social factors influencing HIV prevalence

Figure 5: Distribution of respondents who drink alcohol (drug abuse) (n=100)

Figure 6: Distribution of respondents who go clubbing under the influence of alcohol (n=18)

2.3 Awareness, attitudes and practices of respondents towards HIV preventive measures

Table 4 shows that majority of respondents receive information about HIV/AIDS from hospitals 38(38%), followed by radio programs 32(32%) and newspaper with the least number of respondents 4(4%).

Shows that respondents knew well different HIV preventive measures with condom use taking highest percentage 39.9% followed by abstinence 38.9% being faithful 17.7% and safe male circumcision having the least measure number known by respondents with only 3.5%.

Figure 7: Distribution of respondents by who had ever had sexual intercourse (n=100)

Figure 8: Distribution of respondents who use protection during sexual intercourse among those who had sex (n=66).

Figure 9: Distribution of respondents by how many sexual partners they had (n=100)

Figure 10: Distribution of respondents by those who use contraceptives and those who

Table 1. Distribution of respondents by age group (n=I 00)

Age in years	Frequency	Percentage (%)
13-15	16	16
16-18	52	52
19-21	32	32
Total	100	100

Table 2. Distribution of respondents by their religion (n=100)

Religion	Frequency	Percentage
Catholics	30	30
Protestants	42	42
Muslims	16	16
Born again	10	10
Adventists	2	2
Total	**100**	**100**

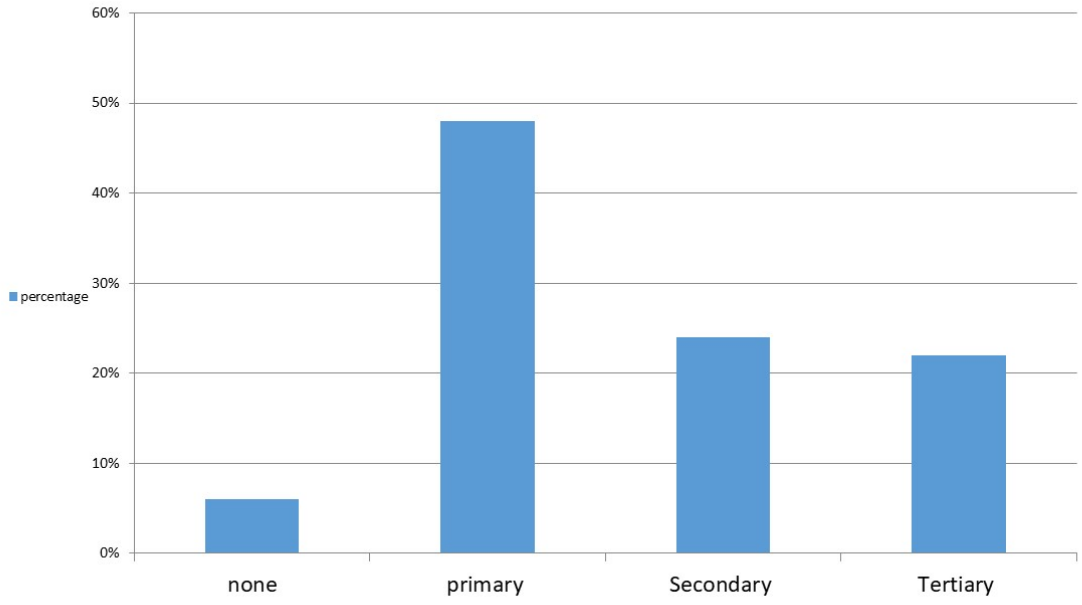


Chart 1. Shows that respondents who attend primary school had the greatest number with 48(48%), followed by secondary level 24(24%), followed by those who attended tertiary level 22(22%), and the least being those who never attended school 6(6%).

Table 3. Distribution of respondents according to occupation. (n=100)

Occupation	Frequency	Percentage %
Students	86	86
Civil servants	4	4
Businessmen/ women	4	4
Peasants	6	6
Total	**100**	**100**

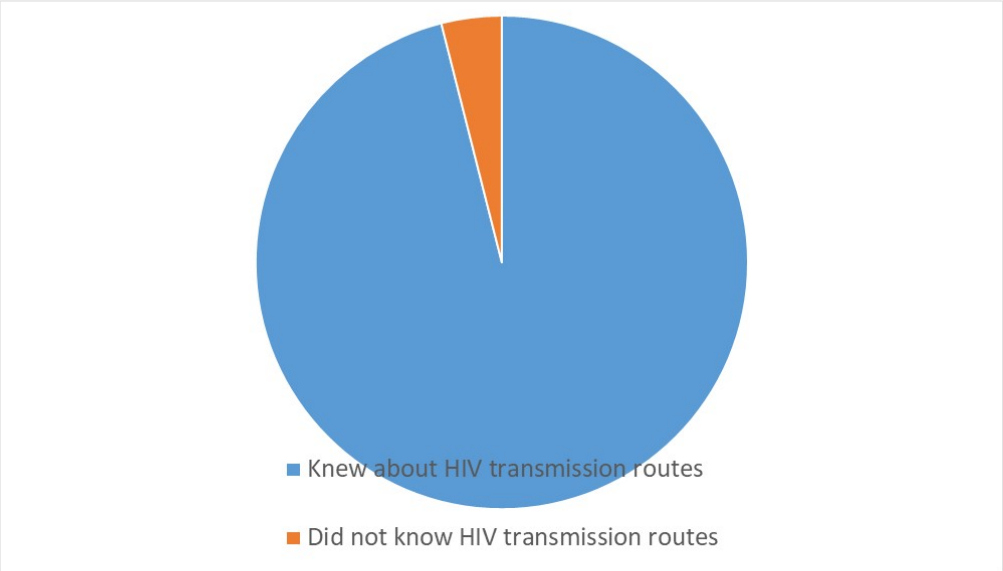


Chart 2. shows that 96(96%) of the respondents knew very well about HIV transmission routes and its preventive measures while 4(4%) did not know.

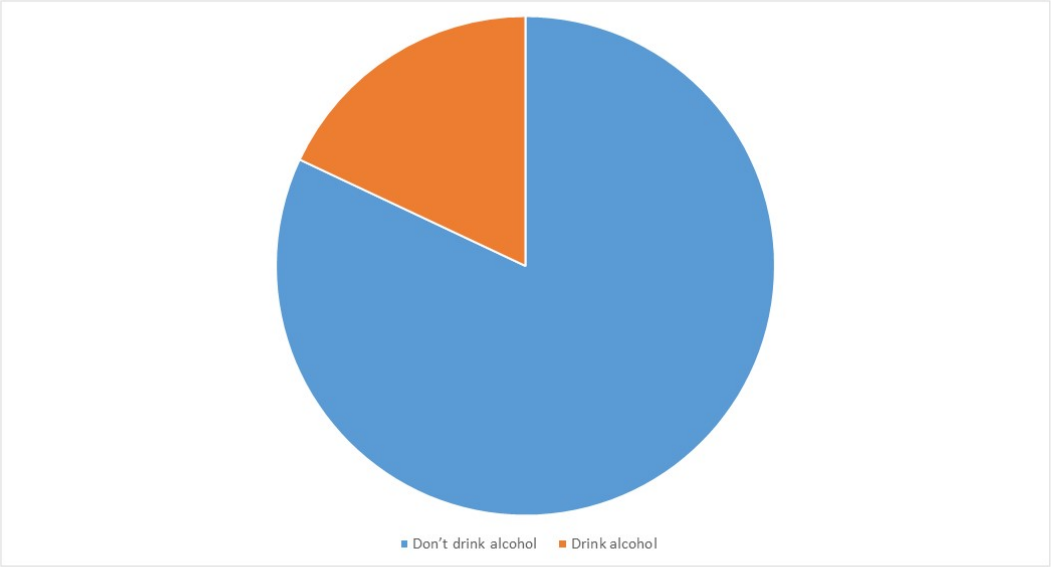


Chart 3. shows that out of 100 respondents, 82% don't drink alcohol while 18(18%) do drink alcohol. Most of respondents don't drink.

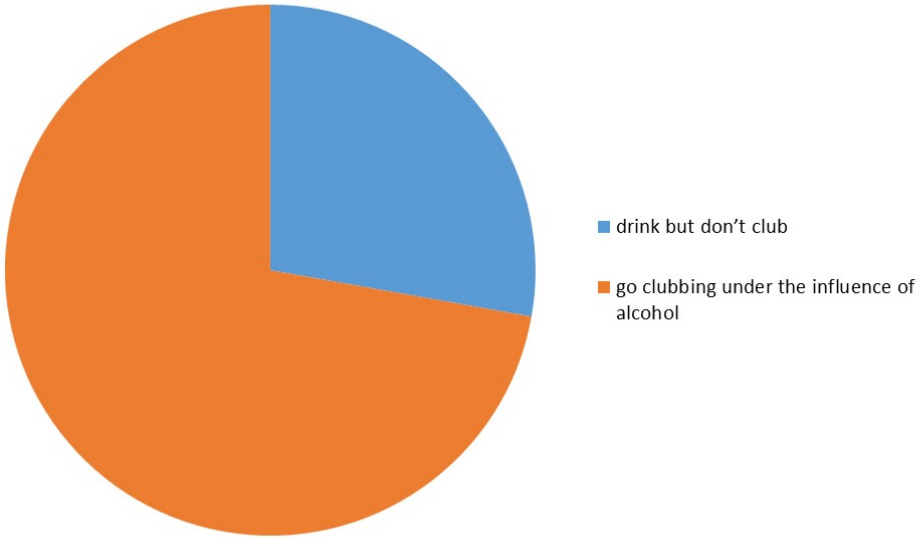


Chart 4. shows that out of the 18 respondents who drink alcohol 5(27.8%) drink but don't club, while 13(72.2%) go clubbing even under alcohol influence. 10/13(76.9%) reported not to have used condoms after because of being tired and to avoid hectic burden. 3/13(23.1%) use condoms consistently after clubbing much as they are expected not to have used them properly.

Table 4. Distribution of respondents by how they acquire knowledge, information on HIV/AIDS (n=100)

Media	Frequency	Percentage
Radios	32	32
Televisions	18	18
Newspapers	04	04
Churches	08	08
Hospitals	38	38
Total	**100**	**100**

Table 5. Distribution of respondents by awareness of HIV preventive measures (n=100)

Preventive measures	Frequency	Percentage
Abstinence	88	38.9%
Being faithful	40	17.7%
Condoms	90	39.9%
Safe male circumcision	8	3.5%
Total	226	100%

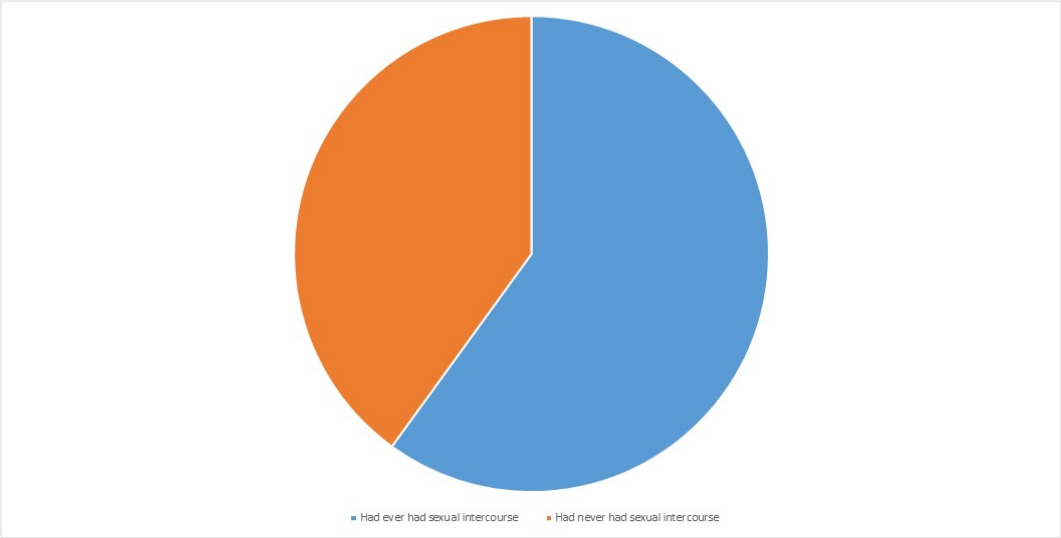


Chart 5. shows that out of 100 respondents, 66(66%) had ever had sexual intercourse and 34(34%) had never had sexual intercourse.

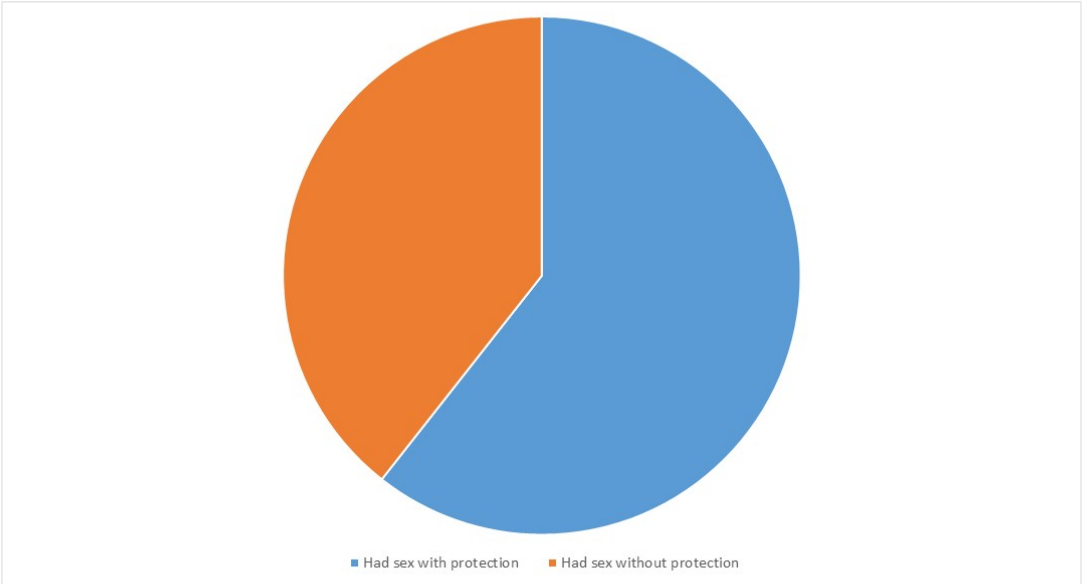


Chart 6. shows that 60.6% of respondents who had sex used protection with condoms while 39.4% out of 66 had unprotected sexual intercourse.

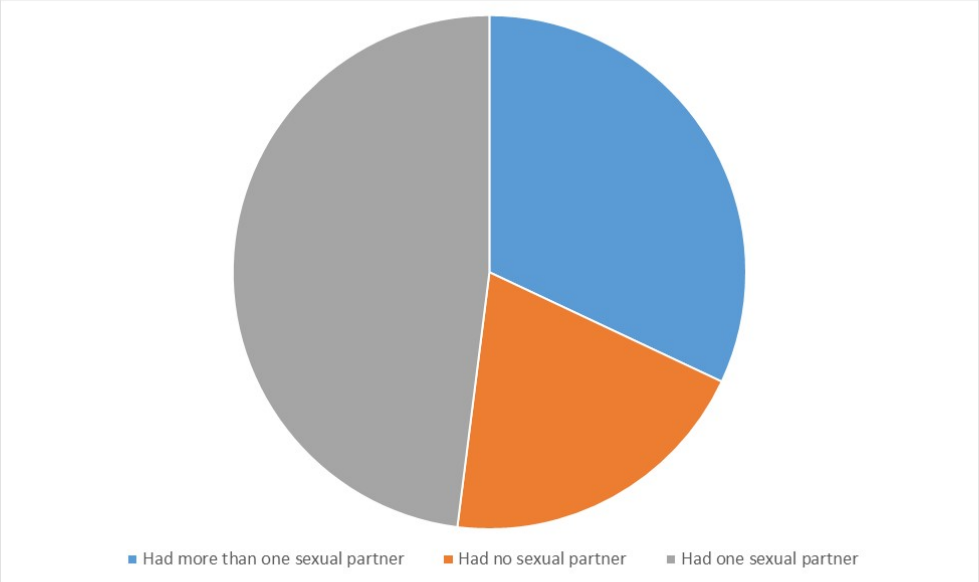
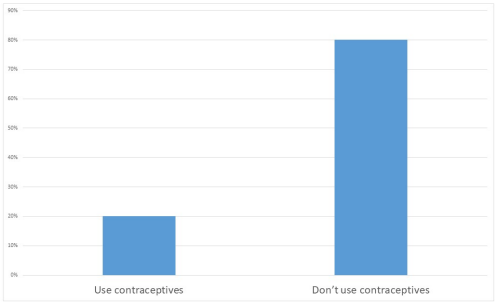


Chart 7. shows that 32% of the respondents had more than 1 sexual partner (multiple sexual partners), 20% had none and 48% had specifically one sexual partner. Majority being with one sexual partner and least with none.

do not use contraceptives but having unprotected sexual intercourse (n=100)



(n = 100)

Figure 11: shows that out of 100 respondents 20(20%) used contraceptives methods mostly postinar-2 and Depo-Provera while 80(80%) did not use contraceptives. 16(80%) of those who use contraceptives (20) had unprotected sex while 4(20%) had protected sex 6(7.5%) of those who did not use contraceptives (80) had un protected sex whereas 74(92.5%) had protected sex intercourse. **Table 6: Distribution of respondents by what attempts them to go for unprotected sexual intercourse (n=100).**

Shows majority of the respondents got tempted to have unprotected sex because of unplanned sexual intercourse with 35(35%), followed by the fear to buy condoms 29(29%), followed by the partner being so beautiful 22(22%), the presence of ARVs that have made HIV appear like any other curable disease with 10(10%) and the least number being 4(4%) due to influence from one partner.

3 Discussion:

The study was done in Hoima Regional Referral Hospital found in Hoima district The study covered 100 adolescents who came for services at HRRH. Most of the adolescents were aged between 16-18 years 52(52%). This high number of adolescents' may explain the increasing threat of HIV/ AIDS by involving themselves in early sexual intercourse and a few having born with it. This is because they are highly active sexually while others are trying sexual intercourse for their first time hence making them curious and this predisposes them to HIV/AIDS more.

The religion of respondents among the 100 respondents, the biggest number were protestants 42(42%), followed by Catholics 30(30%), Muslims 16(16%), Born again 10(10%) and seventhis day Adventist 2(2%). This shows that Protestants were greatly represented. Religion and religious beliefs are the foundations of community life in a majority of societies. Religion prescribes ethical guidelines

Table 6. Distribution of respondents by what attempts them to go for unprotected sexual intercourse

Reason for unprotected sex	Frequency	Percentages (%)
Fear to buy condoms	29	29
Presence of ARVs	10	10
Unplanned sex	35	35
Influence of partners	4	4
When partner is so beautiful	22	22
TOTAL	**100**	**100**

for many aspects of daily life and also navigates belief systems and norms surrounding sexuality. The majority of religiously tailored belief systems condemn premarital sex, contraception including condom use, and homosexuality. Catholic Church in Kenya for example it does not encourage condom use among its congregation and up to now, this is a controversial issue with media houses in Kenya. Some religions also advocate a submissive role for women, foster gender inequality in marital relations, and promote women's ignorance in sexual matters as a symbol of purity (Waithaka,M & Bessinger, R 2001).

The sexuality and gender stereotypes constructed by religion can inhibit prevention efforts and increase vulnerability to HIV infection. HIV vulnerability caused by religious beliefs and practices is the result of religious institutions' denunciation of HIV infection as sinful. Such religious judgments play a significant role in generating HIV- and AIDS-related stigma which increases vulnerability. Religions advocating against condom use pose a serious challenge to preventing the spread of HIV in the communities where they operate. Similarly, religions that denounce homosexuality tend to fuel stigma against those who engage in same sex behavior, thus indirectly increasing their vulnerability to HIV

The marital status of the respondents among 100 respondents the biggest number were single 86(86%) followed by the married 10(10%) and widowers 4(4%). This shows that the singles are most likely to indulge themselves in sexual intercourse and the few married ones who can be unfaithful to either of the couple. Gender inequality in marital relations, especially in sexual decision-making, increases vulnerability to HIV transmission. Trends in current data on new HIV infections suggest that the incidence of HIV is rising among married women and girls worldwide, with unsafe and unprotected heterosexual intercourse being the single most important factor in the transmission of HIV among women (Subbarao, K . & Raney, L. 1995). Marriage, which greatly increases women's sexual exposure, has in itself become a risk factor for women and girls in many countries, for example it is more dangerous for a woman to getting married to a polygamous husband in the name of inheritance (Luo and Luhya culture).

The dramatic rise in the frequency of unprotected sex after marriage is driven by the implications of infidelity or distrust associated with certain forms of contraception such as condoms, a strong desire to become pregnant, and an imbalance in gender power relations. This results in women's increased inability to negotiate safer sex. In spite of having knowledge of their spouse's extra-marital sexual interactions, women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional.

The traditional practice of polygamy, which is legally sanctioned in African culture, allows husbands to have more than one wife. Polygamy operates to create concurrent sexual networks within marriage between multiple wives and their husband, and in addition to any extra-marital sexual contacts the spouse may have. Direct sexual transmission of HIV can occur in these concurrent sexual networks where the virus is introduced through the spouse's extra-marital sexual contacts or where a new wife who is already HIV positive enters the polygamous union. In luo community for example, polygamy is widely accepted with no room to HIV testing and condom use before picking on a new wife.

Early marriage severely increases young girls' vulnerability to HIV as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer

vaginal membranes which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs. Older husbands are more likely to be sexually experienced and HIV infected. The dramatic rise in young married girls' exposure to unprotected sex is driven by pressure to bear children and their inability to negotiate safe sex. The significant age gap in spouses also further intensifies the power differential between husband and wife, which in turn discourages the open communication required to ensure uptake of voluntary counseling and testing for HIV, sharing test results and planning for safe sexual relations throughout the marriage. In Kenya the Turkana community is struggling with early marriages arranged between older men with under aged girls in the name of parents getting cows as wealth.

Gender inequality and patriarchy (social structures where men take primary responsibility and dominate in their households) encourage multiple sexual partners for men inside and outside of marriage, while women are required to be faithful and monogamous. Such socio-cultural practices and norms make men and their partners especially vulnerable to HIV. Luhya, Luo communities and Kalenjin communities in Kenya take women as part of children in the house and have to follow the orders of the usually authoritative husband. The Husband decides on when to sleep with the wife or spend a night elsewhere and no question from the wife. Harmful cultural practices such as widowhood-related rituals, sexual cleansing and female genital cutting heighten the risk of HIV (Subbarao K . & Raney, L. 1995) transmission. Gender-based violence has become common place in almost all societies. Violence has many facets. Within the household this can include battering by an intimate partner, marital rape, and dowry-related violence, and sexual abuse. Violence outside the home can include rape, sexual abuse, sexual harassment and assault. Various social, cultural, and religious norms produce and reinforce gender inequality and the stereotypical gender roles that underpin gender-based violence. Gender-based violence is a key factor in increasing risk of contracting HIV. Sexual violence can result in 'direct transmission' of HIV which can be the result of forced or coercive sexual intercourse with an HIV infected partner. The biological risk of transmission in a violent sexual encounter is determined by the type of sexual exposure (vaginal, anal or oral) (Wight D, et al 2006).

Low levels of education had lack of awareness and poor attitudes and practices towards condom use and other preventive measures, Those with high levels of Education were greatly aware of basic facts about HIV/AIDS and its preventive measures and according to (Eleno Gouws, UNAIDS) most of the cases are due to hetero-sexual intercourse.

Among the 100 respondents 96(96%) were well acquitted with knowledge about HIV basic facts, ways of transmission and 4(4%) did not know very well HIV basic facts, and its routes of transmission. This implies that 4(4%) of the respondents need more health education otherwise they are more likely to contract HIV/AIDS than those who well knew about HIV/ AIDS. Young women in particular, especially for those who have completed secondary school (Albert Kilian, 1999) presents data from Uganda in which these women showed the strongest decline in HIV prevalence, whereas the risk for illiterate women remained high. Secondary school students in one of the districts of the study reported higher levels of knowledge on HIV prevention and more positive attitudes towards AIDS patients. Recent evidence is telling of the significant impact of education on HIV prevalence rates (statistics taken from (Herz and Sperling, 2004 and World Bank, 2002):

In 1998, a 72-country analysis finds that where the literacy gap between boys and girls exceeds 25 percent, HIV prevalence exceeds 5 percent. Conversely, where the literacy gap is below 5 percent, HIV prevalence falls below 3 percent;

A Zambian study finds that AIDS spreads twice as fast among uneducated girls (Vandemoortele and Delamonica, 2000);

Another Zambian study finds a marked decline in HIV prevalence rates in 15–19 year-old boys and girls with a medium to higher educational level, but an increase among those with lower education levels (Kelly, 2000);

Young rural Ugandans with secondary education are three times less likely than those with no education to be HIV-positive (De Walque, 2002); In Zimbabwe, secondary education had a protective effect against HIV infection for women that lasted into early adulthood. Girls aged 15-18 who had dropped out of school were six times more likely to be HIV positive than those who were still enrolled (Gregson, Waddell and Chandiwana, 2001); Some

analysis suggests that 700,000 cases of HIV would be prevented each year globally if all children received a complete primary education (five to six years of schooling) (Bruns, Mingat and Rakotomalala 2003).

14% may become complacency towards protected sex knowing HIV/AIDS has curative drug hence increasing their chances of acquiring HIV/AIDS than those who knew that ARVs are not curative drugs for HIV/ AIDS as found out by this study.

According to the study findings, those who drink alcohol are 18% and 82% do not drink alcohol. In additional, 13/18(72.2%) go clubbing under its influence while 5/18(27.8%) don't go clubbing much as they drink. Hence, there are similar findings by the study conducted to understand alcohol and other substance abuse influence on the spread of HIV/AIDS. It stated that, although HIV/AIDS can affect anyone, the risk of infection is significantly higher in patients suffering from substance abuse, whether the risk is of direct exposure through needles or increased likelihood of high risk behavior due to loss of judgment. Substance abuse is of primary concern to HIV/AIDS by promoting actions which increase the initial risk of infection (Brick J, 2004). Furthermore, some abused substances can also influence disease progression and interfere with the effectiveness of treatment.

In addition to the above, 10/13(76.9%) reported not to have used condoms because of being tired and to avoid hectic burden and care taken when using condoms. 3/13 (23.1%) use condoms consistently after clubbing much as they are expected not to have used them properly.

This implies that those who drink and go clubbing under the influence of alcohol stand high chances of contracting HIV/ AIDS through having unprotected sex and improper use of condoms than those who don't drink 82% of respondents.

Also 39.4% of 66 who indulged in unprotected sexual intercourse standard more chances of acquiring HIV/AIDS than the 60.6% who use condoms for protection.

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Results further showed that out 100 respondents, 20(20%) use contraceptives while 80(80%) don't use contraceptives which are mainly postinar-2 and Depo-Provera.

Hence, most respondents use contraceptives to help them in having unprotected sex but without the unwanted pregnancies. This has played a very big role in increasing chances of HIV transmission because it renders one person a chance to move freely from one person to another through multiple sexual partners which may ease HIV transmissions.

Most respondents had unplanned sex with 35(35%) and fear to buy condoms 29(29%) while the least limiting factor of protected sex was influence of another partner 4(4%). These findings similarly relate to the study results that were looking at awareness, attitudes and practices of respondents towards HIV preventive measures which revealed that high number were of the preventive measures with condom use (Meekers D, Klein M, Foyet L, 2003). Using data from a survey conducted in July – august 2000 among a representative sample of 1956 unmarried youth aged 15-24 years. The data show that in urban Cameroon, first intercourse often occurs at an early age. Despite the HIV epidemic, a substantial fraction of youth, particularly males, continue to have high rates of partner change. A substantial fraction of youth consistently uses condoms with casual partners. However, consistent condom use in regular relationships remains low, even though many youth have multiple regular partners (Meekers D, Klein M, Foyet L, 2003).

4 Conclusion:

A wider spread of knowledge about the benefits of HIV preventive measures and HIV basic facts was revealed. The involvement of other sectors of community like local councils, learning institutions, churches, civil society organizations and NGOs will do a long way in promoting effective knowledge to the adolescents about HIV preventive measures. All these have a high power in educating youth and the entire population about HIV/AIDS information.

In additional, formal education to the adolescents is very important in order to bridge the gap of low education levels influence on the increase of HIV transmission.

Although high emphasis has been put into preventive measures, some still need much sensitization like safe male circumcision and being faithful to each-other,

More health education needed to be passed on to adolescents in schools, hospitals about the relationship between drinking alcohol and HIV such

that mostly they avoid the issue of drug abusing and even clubbing under alcohol influence.

There is however a great misconception about condom use for that matter a higher level of financial support at all stages will be required if the prevention, control, care and treatment objectives are to be achieved.

Much is still needed in spelling out the misconception of contraceptives use in which most people fear unwanted pregnancies with short term out comings than HIV/AIDS severe and long term effects.

Recommendation:

The government through the ministry of health should continue to sensitize adolescents through health education about ABC strategies and safe male circumcision importance in an effort to combat HIV new infections.

The government should also make the services available at village clinics and freely accessible since many adolescents fear to buy condoms.

The government through the ministry of health should advocate for HIV/AIDS testing and counseling, positive living, acceptance, openness to the public about one's status and formation of

Organization among the affected adolescents in order to fight stigma and discrimination.

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