

KNOWLEDGE ABOUT HIV/AIDS OF COLLEGE ATHLETES IN KENYA

E. R. Gitonga



THE HIV/AIDS PANDEMIC HAS HAD NEGATIVE impacts on individual families through losses of loved ones, break-ups of families, increases in families headed by children, declines in school environments, and spillages of orphans in the streets. Impacts had also been felt through reduced economic productivity, and medical costs (WHO, 1995).

AIDS is caused by a form of retrovirus, Human Immunodeficiency Virus, (HIV). HIV destroys T4-helper white blood cells, essential for the body's immune defenses. This leads to body immunodeficiency, giving way to opportunistic infections and eventual death (Becker & Joseph, 1988).

WHO's global program on AIDS (WHO/GPA) estimated by mid-1995 there would be more than 20 million people infected worldwide by the virus causing AIDS. Of those infected, 11 million would be in sub-Saharan Africa, with approximately one million infected individuals living in Kenya.

In Kenya, the first indigenous AIDS case was diagnosed in 1984; by the end of that year, seven cases had been identified. However, there had been gross under reporting and under diagnoses of HIV and AIDS cases for a number of reasons—i.e., people not seeking hospital care for AIDS, doctors/health workers not wanting to report diagnoses of AIDS because of stigmas attached to the disease (WHO, 1994). Ran, Forsythe, and Okeyo (1996) postulated by 2000, national prevalence rate could reach 10%, as one in ten adult Kenyans could be infected with HIV/AIDS. They predicted by 2005 infected people could be well over 20 million.

In 1999, HIV/AIDS was declared a national disaster by the president. Currently, it is estimated 700 people die daily in Kenya due to AIDS related illnesses (250,000 deaths in Kenya per year).

Major mode of transmitting HIV in Kenya, as in other parts of the world, is through heterosexual relations. The pandemic primarily affects young sexually active adults, those between ages of 15 and 50 years (Ran & Forsythe, 1996).

Over the years, a number of studies on HIV/AIDS had been done in Kenya—targeting adolescents (Lema & Hasssan, 1994), secondary school students (Konings, 1994), and university students (Sindiga & Lukhado, 1993; Lidaziba, 2000). These were groups assumed to be most vulnerable to HIV/AIDS.

Within this framework, this study investigated sexual risk-taking behaviors, and preventing HIV/AIDS of teacher education trainees in Kenya. These students fell within the vulnerable age bracket, as a majority were between 20 and 26 years of age. The study targeted athletes, as they might be more vulnerable to HIV/AIDS, due to exposures to new and diverse environments in their sporting endeavors, which could be conducive for transmitting HIV/AIDS. Eboh (1995) acknowledged athletes exhibited carefree sexual behaviours, as many changed lovers, and traveled bizarre, exciting, and fast paced party lives in which they were often seduced by strangers, (gay or straight), or found themselves pumped up after

games looking for company on sleepless lonely nights on the road (*Sun-Sentinel*, 1991). Athletes were also at risk of HIV infection from sharing needles used to inject steroids, hormones, vitamins, or illegal drugs (Nattiv & Puffer, 1991). *Sun-Sentinel* (1991) observed athletes shared personal items, such as razors, tooth brushes, and nail clippers.

Therefore, this study was guided by the following hypotheses—

- There is no significant difference in knowledge of sexual risk taking behaviors between male and female athletes.
- There is no significant difference in knowledge of condom uses between male and female athletes.
- There is no significant difference in perceptions of risks of contracting HIV/AIDS between male and female athletes.
- There is no significant difference in knowledges of transmitting and preventing HIV/AIDS between male and female athletes.

METHODS AND PROCEDURES:

Sample



THE STUDY CONSISTED OF 172 ATHLETES WHO represented Kilimambogo Teachers College during 2001 intercollegiate ball games in soccer, field hockey, handball, basketball, volleyball, and netball. The athletes were informed of purposes of the study, and volunteered to take part, after signing informed consent forms.

Questionnaire



QUESTIONNAIRE WAS DESIGNED BY THE INVESTIGATOR after a robust review of related literature. It consisted of 37 items, distributed into five sections—(1) *sexual risk taking behaviors* (5 items), (2) *knowledge about condom uses* (4 items), (3) *perceptions of risks of contracting HIV* (2 items), (4) *modes of transmitting HIV/AIDS* (13 items), and (5) *preventing HIV/AIDS* (13 items). Items in sections focusing on knowledge about risk taking behaviors, perceptions of risks of contracting HIV/AIDS, and knowledge about condom uses were weighed in a traditional Likert-type scale of *agree, undecided, and disagree*. Positive response alternatives were scored 3-2-1 respectively, and negative items scored in the reverse.

Items centering on knowledges of modes of transmitting and preventing HIV/AIDS were weighted on options of *true, false, and not sure*. Correctly matched responses were scored one, while incorrectly matched responses scored zero. The questionnaire was pilot-tested for reliability among athletes who did not qualify to represent the college in the intercollegiate games. Split-half method yielded a reliability coefficient of ($r=0.80$), considered sufficiently high.

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Data Analyses

DATA WERE MANUALLY ANALYZED FOR FREQUENCIES, means, standard deviations, and percentages. The first three hypotheses were tested inferentially with chi-square tests of independent samples, and the fourth hypothesis subjected to Students t-test. Hypotheses were tested at the 0.05 level of significance.

RESULTS AND DISCUSSION

DEMOGRAPHIC INFORMATION REVEALED 48 MALES and 64 females had questionnaires processed, return rate of 75.11%. Males ranged in ages between 19 and 33 years ($M=22.90 \pm 5.07$); females ranged in age between 19 and 30 years ($M=23.17 \pm 5.21$).

Table 1 reveals computed X^2 of 12.47 was less than table value of 31.47 ($p>0.05$); thus no significant difference in knowledge of sex risk behaviors between these male and female athletes. Consequently, the hypothesis of no significant difference in knowledge of sexual risk taking behaviors between these male and female athletes was accepted.

Table 1. Comparison of Sexual Risk Taking Behaviors of Male and Female Athletes

	MALES			FEMALES			X^2
	Agree	Disagree	Undecided	Agree	Disagree	Undecided	
1. Keeping to one sex partner is boring	6(12.5)	38(79.16)	4(8.3)	4(6.25)	58(90.6)	2(3.12)	3.03
2. Sex on first date is not a big deal.	10(20.3)	32(66.67)	6(12.5)	6(9.37)	48(75)	10(15.62)	2.96
3. Sex after drinking beer is fantastic.	9(18.75)	35(72.91)	4(8.3)	6(9.37)	49(76.56)	9(14.06)	2.62
4. Abstinence from sex is punishing oneself.	7(14.58)	37(77.08)	4(8.3)	6(9.37)	55(85.93)	3(4.68)	2.33
5. Having sexual intercourse weekly is healthy.	3(6.25)	42(87.5)	3(6.25)	4(6.25)	55(85.93)	5(7.81)	2.73

$X^2_{.05} = 31.47$ $X^2 = 12.47$

Figures in parenthesis are percentages

Table 2 shows computed X^2 of 7.80 was less than table value of 25.00 ($p>0.05$); thus, no significant differences in knowledge of condom uses by these male and female athletes. Hence, the hypothesis of no significant difference in knowledge of condom uses by these male and female athletes was accepted.

Table 2. Comparison of Knowledge of Condom Uses of Male and Female Athletes

	MALES			FEMALES			X^2
	Agree	Disagree	Undecided	Agree	Disagree	Undecided	
Using a condom during sex is a waste of time, money, and pleasure.	14(29.16)	31(64.58)	3(6.25)	17(26.50)	41(64.06)	6(9.37)	1.62
Condoms cannot be used every time one has sex.	13(27.08)	26(54.16)	9(18.75)	22(34.37)	31(48.43)	11(17.18)	0.64
My partner does not allow me to use a condom.	12(25)	19(39.58)	17(35.41)	12(18.75)	32(50)	20(31.25)	4.51
Condoms sometimes get stuck in the female partner.	22(45.83)	12(25)	14(29.16)	33(51.56)	11(17.18)	20(31.25)	1.03

$X^2_{.05} = 25.00$ $X^2 = 7.80$

Figures in parenthesis are percentages

Table 3 shows computed X^2 of 15.55 was greater than table value of 9.84 ($p<0.05$); thus, there was a significant difference in perceptions of contracting HIV by these male and female athletes. Thus, the hypothesis of no significant difference in perceptions of risk of contracting HIV/AIDS between these male and female athletes was rejected.

Tables 4(a) and (b) present comparisons of these athletes knowledges on modes of transmitting and preventing HIV/AIDS. Results in Table 4(a) reveal athletes knowledges on modes of transmitting HIV/AIDS did not differ significantly between these male and female athletes.

Results in Table 4(b) indicate no significant difference between these males and females knowledges on preventing HIV/AIDS. Thus, the hypothesis of no significant difference in knowledges of transmitting and preventing HIV/AIDS between these male and female athletes was accepted.

Table 3. Comparison of Perceptions of Contracting HIV of Male and Female Athletes

	MALES			FEMALES			X^2
	Agree	Disagree	Undecided	Agree	Disagree	Undecided	
I am not likely to get HIV/AIDS.	16(33.33)	17(35.41)	15(31.25)	27(42.18)	22(34.37)	15(23.43)	14.92
I am not the type of person who can catch HIV/AIDS.	14(29.16)	26(54.16)	8(16.67)	17(26.56)	39(60.93)	8(12.5)	0.633

$X^2_{.05} = 9.84$ $X^2 = 15.55$

Table 4(a). Comparison of Athletes Knowledges on Modes of Transmitting HIV/AIDS

	N	X	SD	T-cal	t-critical	Df
Males	48	63.25	15.83	-0.15	1.1658	110
Females	64	63.5	13.89			

$t_{.05} = 1.658$

Table 4(b). Comparison of Athletes Knowledges on Preventing HIV/AIDS

	N	X	SD	T-cal	t-critical	Df
Males	48	68.05	12.99	0.018	1.658	110
Females	64	68.1	12.77			

$t_{.05} = 1.658$

Discussion

PURPOSE OF THIS STUDY WAS TO DETERMINE sexual risk taking behaviors, condom uses, perceptions of contracting HIV/AIDS, knowledges about modes of transmitting and preventing HIV/AIDS of college athletes. A majority (38%) of these athletes did not perceive themselves to be at risk of contracting HIV/AIDS. Findings were in agreement with Agostinelli and Seal (1992) observations that young adults did not perceive themselves to be at risk of contracting HIV/AIDS. This was worrisome because only when an individual perceives oneself to be at risk of contracting HIV/AIDS, recommended preventative action could be likely (Becker & Joseph, 1988). This lack of perception of vulnerability could be attributed to the fact

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HIV/AIDS was still believed to be a disease of westerners, barmaids, commercial sexual workers, and truck drivers!

It was apparent condom uses did not differ according to gender. However, these athletes did exhibit different opinions over uses of condoms. Negative attitudes towards condom uses could have been due to inadequate knowledges through such beliefs as shown by the athletes that condoms reduced sexual pleasure, could not be used always, and could get stuck in the female partner. Similar findings were reported by Sindiga and Lukhado (1993), and Sabwa (2000). Negative attitudes towards uses of condoms during sexual intercourse were also supported by religious antagonisms towards uses of condoms, and beliefs condoms were a *western* solution to spread of HIV/AIDS as propounded by government policies on HIV/AIDS between 1988 and 1991 (Ran & Forsythe, 1996).

The study revealed these athletes' knowledges about sexual risk taking behaviors were inadequate. This increased vulnerabilities of these athletes to the scourge of HIV/AIDS. However, Obudho (1992) lamented low knowledges of risk sexual behaviors might have negative impacts on athletes actual sexual behaviors.

Findings did not indicate any significant differences in knowledges about modes of transmitting HIV/AIDS. However, these female athletes had more knowledge than the male athletes about this aspect of HIV/AIDS. This corroborated Varga and Makubalo (1996) assertion females had more knowledges regarding acquiring and transmitting HIV/AIDS. This was coupled with wrong beliefs and misinformation, such as one cannot get HIV/AIDS by having sex with a virgin, can get HIV/AIDS by living with a person with HIV/AIDS, shaking hands with a person infected with HIV/AIDS. Of particular interest was over 80% of these athletes did not know some cultural practices, such as tattooing, was considered one way of transmitting HIV/AIDS, especially when instruments were not sterilized.

Findings revealed no significant difference in knowledge about preventing HIV/AIDS between these male and female athletes. However, female athletes had more knowledges on modes of preventing the disease. Results were similar to Koning's (1994) observation that students knowledges on major aspects of AIDS prevention were high, but punctuated with wrong and negative misconceptions, such as partner selection, swapping positions, practicing withdrawal during sex, and having sex gently with the partner.

Findings indicated 64.28% of these athletes wanted to have a HIV test, while a large number 40 (35.72%) did not want to have such a test. This was worrisome since, however much the government continues to encourage people to know their HIV status, stigmatization of the disease by society prompts many people not to go for the tests. It is only after establishing ones HIV status can one take necessary measures, to participate effectively, and sensitize others about seriousness of this pandemic.

CONCLUSION AND RECOMMENDATIONS

THE STUDY ESTABLISHED THESE ATHLETES DID NOT perceive themselves to be at risk of contracting HIV/AIDS, sexual risk taking behaviors were wanting, knowledges of condom uses and modes of transmitting and preventing HIV/AIDS inadequate. Therefore, it was asserted college athletes were vulnerable to the scourge of HIV/AIDS. Bearing in mind the findings, the following recommendations are made—

- **Need for comprehensive education programs at all levels of education to increase athletes knowledges about major aspects of HIV/AIDS.**
- **Need for coaches to integrate AIDS education with their training of athletes. More particularly, they should help athletes develop high perceptions about vulnerability of HIV/AIDS.**
- **Need to avail health care facilities in educational institutions where athletes can be tested for HIV.**
- **Further studies should be done encompassing more athletes at different levels of participation in sport.**

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