KNOWLEDGE OF HUMAN IMMUNO DEFICIENCY VIRUS/ACQUIRED IMMUNO DEFICIENCY SYNDROME (HIV/AIDS) AMONG SECONDARY SCHOOL ADOLESCENTS IN ZARIA METROPOLIS: IMPLICATIONS FOR COUNSELLING

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A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS DEGREE IN EDUCATION.

DEPARTMENT OF EDUCATION
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ZARIA

SEPTEMBER, 2011

DECLARATION

I hereby declare that this thesis entitled "Knowledge of Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS) among secondary schools adolescents in Zaria Metropolis: Implications for Counselling", submitted for the award of Masters of Education (M.Ed) Degree in Education has been written and compiled by me. It has not been presented in any previous application for higher degree. All sources of information derived from literatures have been duly acknowledged in the text by way of references.

Williams, Nwanyinnaya Charity ____________________
Signature

CERTIFICATION

The thesis entitled "Knowledge of Human Immuno Deficiency Virus / Acquired Immuno Deficiency Syndrome (HIV/AIDS) among secondary schools adolescents in Zaria Metropolis: Implications for Counselling", by Williams, Nwanyinnaya Charity meets the regulations governing the award of the degree of Masters in Education of Ahmadu Bello University, Zaria and it is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This thesis is dedicated to God, the creator of heaven and earth, the giver of life and to my beloved husband, Dr. I.S. Williams, for his care and support while I was undergoing the study.

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ABSTRACT

The researcher investigated "Knowledge of Human Immuno Deficiency Virus / Acquired Immuno Deficiency Syndrome (HIV/AIDS) among secondary schools adolescents in Zaria Metropolis: Implications for Counselling". The problem of HIV/AIDS is alarming that the researcher tried to find out the actual knowledge of HIV/AIDS among secondary school adolescents in Zaria metropolis. The objectives of the study are to ascertain the level of knowledge on the causes of HIV/AIDS, the behaviour that leads to high risk of the infection, signs and symptoms and preventive measures used in reducing HIV/AIDS among secondary school adolescents in Zaria metropolis. For a representative view, the researcher randomly selected her samples and administered structured questionnaire on 431 adolescents. All the respondents returned completed copies of the questionnaire which were found usable because the items were properly and completely answered. Four research questions and hypotheses were set for this research. They focused on the level of knowledge of HIV/AIDS among secondary school adolescents in Zaria Metropolis. Frequency counts, percentages and independent t-test were the statistical tools used in the analysis of data procured from the research questions and hypotheses. The findings were firstly that there was significant difference in the knowledge of the causes of HIV/AIDS among secondary school adolescents in Zaria metropolis. Secondly, there was significant difference in the knowledge of behaviour that leads to high risk of HIV/AIDS infection among the subjects. Thirdly, there was no significant difference in the knowledge of preventive measures adopted to reduce HIV/AIDS among secondary school adolescents in Zaria metropolis. It was concluded that there was need for HIV/AIDS counselling for adolescents in general. The main recommendation was that information about HIV/AIDS should be made available to adolescents in their schools, hostels, homes, libraries, public gatherings and places of worship. Curriculum experts in health education are to incorporate concepts and topics on HIV/AIDS education in the contents of their textbook.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDIX

LIST OF ABBREVIATIONS

UNAIDS	-	United Nations AIDS Programme
HIV	-	Human Immuno Deficiency Virus
AIDS	-	Acquired Immuno Deficiency Syndrome
MTCF	-	Mother to Child Transmission
STDs	-	Sexual Transmitted Diseases
ARHC	-	Adolescents Reproductive Health Care
NPE	-	National Policy on Education
WHO	-	World Health Organisation
UN	-	United Nations
NCE	-	Nigeria Certificate in Education

OPERATIONAL DEFINITION OF TERMS

Stigma	A strong feeling in society that a type of behaviour is shameful.
Scourge	To cause a lot of harm suffering to a place or group of people: country scourged by diseases or war.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

One of the most dreaded killer diseases in the world today is the Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome, otherwise known as HIV/AIDS. It is also the greatest challenge that national and international health workers, organizations, government and civil societies face in the battle to provide treatment to an ever-expanding infected population, especially, in the developing world. The world has spent a lot (in cash and in kind) tackling issues of prevention, stigma, drugs, infrastructure, human resources and cost of treatment for HIV/AIDS. These efforts all combine to account for the challenges and obstacles in tackling this viral disease.

Against the backdrop of other chronic health problems in Nigeria, many of which still continue to provoke high morbidity and mortality, AIDS has assumed a visibility rarely seen in respect of many health issues. Thus, averting a possible pandemic with its attendant sudden adverse consequences of economic and social destabilization is a major concern. AIDS has become the public health problem that has touched every nook and cranny of the world. It is one of the killer diseases of public health importance that threatened the supposed target year 2010 for improved health related conditions and health status. Weise (1997) described AIDS as one of the pandemics of the late 20th century.

Knowledge is described by Carlson(1996) as the sum of people's conceptions, views and perceptions which have been established and tested as correct reflection of objective reality. Therefore knowledge in this study is referred to as all understanding based on perception, the reality of which is proved in human practice.

General knowledge of AIDS seems to be low among adolescents in Zaria metropolis. Lack of knowledge may be one of the reasons why people are actively engaged in indiscriminate sexual behaviours which culminate in contracting AIDS. Florio & Stafford in Jatau & Kajang (2002) lend credence to the above assertion and contended that partial or low knowledge confers unwarranted sense of security which beclouds one's alertness to risk, danger and hazard.

Lack of knowledge of AIDS predisposes many adolescents to the dreaded disease. This ugly situation prompted Ademuwagun (1990), to stress that AIDS education should start from the primary school to the tertiary level. Adolescents need to be educated about AIDS, in that AIDS education will help them to develop positive attitudes towards AIDS and avoid practices that can make them prone to the disease.

The United Nations AIDS Programme, UNAIDS (1998) discussing adolescents in relation to HIV/AIDS indicated that adolescence is considered to be a period of development marked by discovery and experimentation that come with a number of physical and emotional changes. Sexual behaviour and drug use are often part of this exploration or experimentation. During this time of growth and change, adolescents get mixed messages. This is because double standards exist for girls who are expected to remain as virgins and boys who are pressured to prove their manhood through sexual activity and aggressiveness.

Those adolescents are urged to remain abstainers from premature sex while surrounded by pornographic images on television, movies, and magazines of glamour people having sex, smoking and drinking alcohol. In most of sub-Sahara Africa including northern and southern Nigeria, people use the cover of religion, culture and morality to deny adolescents access to information about their reproductive health, the knowledge of which if can enhance their safety and ensure good health. This knowledge in turn will reduce their chances of falling easy preys to HIV/AIDS.

Knowledge in relation to HIV/AIDS is the focus of this study. However, the study emphasizes on knowledge of HIV/AIDS among adolescents. This is because counselling is one of the major gateways to reduce the spread of HIV/AIDS. Counselling has emerged as an effective intervention strategy in addressing the HIV/AIDS pandemic in many parts of the world infected with the problem. Previous studies showed that groups and organizations involved in combating HIV/AIDS tended to lay emphasis on treatment rather than engaging in activities that can educate and create awareness in the society. The targeted society in this study is Zaria which is a town in the north of Kaduna State. Zaria is a distance of 70 km from Kaduna metropolis which is the capital of Kaduna State. Zaria is predominantly inhabited by Muslims who are Hausa Fulanis. The major language spoken in Zaria is Hausa. The major occupations of the people are trading and handcrafts. Zaria, as the seat of the Zazzau Emirate council, has one of the highest concentrations of higher institutions of learning in Nigeria. Zaria people are very friendly and hospitable.

1.2 Statement of the Problem

In Nigeria, if there is an HIV/AIDS free generation, everybody will have the opportunity to go about his or her normal business, thereby, making the economy a viable and sustainable one. However, a nation that is sick and plagued with the scourge of

HIV/AIDS may not experience economic prosperity because HIV/AIDS carries along with it a lot of politico-socio-economic consequences. An individual who tests HIV/AIDS positive may develop a feeling of guilt, shame, disgrace and anger which may lead to retardation of success in all ramifications of life.

Efforts have been made by some states to provide sexuality education and counselling programmes Examples of such states are Benue, Akwa Ibom and Cross Rivers. However, such efforts have not yielded much success in educating the adolescents on HIV/AIDS.

According to the World Health Organization (2004), adolescents are infected by HIV/AIDS because the youths often do not know how serious the HIV/AIDS pandemic is, its causes, prevention and protection. The researcher observed that many adolescents in Nigeria do not have free access to information about HIV/AIDS. This is because, on many occasions adolescents engage in high risk behaviours without knowing the serious consequences of such risky behavioural manifestations.

In addition, studies on HIV/AIDS have been conducted using people of various ages around the world, and even in Nigeria, but none seems to have assessed adolescents' level of knowledge of HIV/AIDS. This reason necessitated the study on knowledge of HIV/AIDS among adolescents in Zaria metropolis of Kaduna State.

1.3 Objectives of the Study

In carrying out this research the following objectives were set:

1. to ascertain the level of knowledge on causes of HIV/AIDS among adolescents in secondary schools in Zaria Metropolis

2. to identify the level of knowledge on the behaviour that leads to high risk of HIV/AIDS infection among secondary school adolescents in Zaria Metropolis
3. to ascertain the level of knowledge on the signs and symptoms of HIV/AIDS among secondary school adolescents in Zaria Metropolis.
4. to identify the level of knowledge of preventive measures used in reducing HIV/AIDS among secondary school adolescents in Zaria Metropolis.

1.4 Research Questions

The following research questions were raised to guide the investigation.

1. What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria Metropolis on the causes of HIV/AIDS?
2. What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria Metropolis on the behaviours that lead to high risk of HIV/AIDS infections?
3. What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria Metropolis on the signs and symptoms of HIV/AIDS?
4. What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria Metropolis on the preventive measures to be used to reduce HIV/AIDS infection?

1.5 Research Hypotheses

The following null hypotheses were formulated and tested to guide the study.

1. There is no significant difference on the knowledge level of the causes of HIV/AIDS among male and female secondary school adolescents in Zaria Metropolis.

2. There is no significant difference on the knowledge level of behaviours that lead to high risk of HIV/AIDS infections among male and female secondary school adolescents in Zaria Metropolis.
3. There is no significant difference on the knowledge level of the signs and symptoms of HIV/AIDS among secondary school adolescents in Zaria Metropolis.
4. There is no significant difference on the knowledge level on preventive measures to reduce HIV/AIDS among secondary school adolescents in Zaria Metropolis.

1.6 Basic Assumptions

This study is based on the following assumptions:

1. The secondary school adolescents will be fully aware of the implications of HIV/AIDS infection.
2. The teachers can also inculcate the knowledge of HIV/AIDS prevention in adolescents.

1.7 Significance of the Study

The HIV/AIDS scourge has grown to such a magnitude that it is now a global problem. It is hoped that this study will motivate the adolescents especially in Zaria Metropolis, their parents, guardians and the general public towards behavioural changes that will prevent the spread of HIV/AIDS. It will also alert them to the existence of the dreaded disease. The study will also create the sense of awareness necessary for guarding adolescents from being victims of the disease.

The information gathered will be useful to adolescents as well as lecturers, healthcare providers in schools and colleges, health educators and social workers. The findings will help the adolescents, health workers and social workers to come up with strategies through which they can combat the disease through health promotion and education.

The findings derived from this study will be of tremendous help to the state and local government officials in providing appropriate seminars and conferences for health workers and take counselling measures to be used for people living with HIV/AIDS.

The study also will serve as a useful guide to the private sector as it will help them to proffer solutions on how to reduce the scourge of HIV/AIDS. This can be done through symposia, workshops, talk shows, conferences, role-play and simulation with the help of resource persons.

In addition, the religious groups in the state and especially Zaria metropolis will utilize this information by organizing training and counselling workshops for the youths, teachers and parents. The findings of the research will be used to counsel the adolescents with or without HIV/AIDS knowledge. Finally, this study will, hopefully, be a valuable contribution to knowledge, as well as serve as reference material for future scholars.

1.8 Scope and Delimitation of the Study

The study was restricted to adolescents in secondary schools in Zaria metropolis. The population used included both male and female adolescents in secondary school within Zaria metropolis.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

In this chapter, some related studies, both outside and inside Nigeria are reviewed. The following sub-headings are reviewed in the chapter: the concept of (HIV/AIDS), concept of Guidance and Counselling, the concept of adolescence, adolescents' ignorance of HIV/AIDS/STDs, empirical studies, theoretical framework, and summary.

2.1 The Concept of Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS).

Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome (HIV/AIDS) are two different acronyms describing two related concepts. There are different illnesses caused by viruses which may not be HIV. These include, cold (catarrh), measles, hepatitis A, B, and C, Chicken pox, polio and so on. The human immunodeficiency virus that causes AIDS is a type of virus called retrourus. It is very tiny to see with the naked eyes except with the help of an instrument called microscope. Garland (2003) posited that HIV is so small that 230,000 viruses could be compared to the point of a pen or a full stop at the end of a sentence.

2.1.1 Origin of HIV/AIDS

The origin of HIV/AIDS is not known, but scientists have proposed theories about the origin of HIV/AIDS none of which has yet been proven. Haan (2004) stated that the earliest known case of HIV was from a blood sample collected in 1959 from a man in Kinshasa, Democratic Republic of Congo. The genetic analysis of this blood sample suggested that HIV – 1 may have stemmed from a single virus in the late 1940s or early 1950s. Haan (2004) went on to state that the virus existed in the United States by the mid- to late 1970. Doctors in Los Angeles and New York reported illnesses of Pneumonia, Cancer and others among people with healthy immune system. In 1982, AIDS was used by health officials to describe the occurrence of such opportunistic infections as Kaposis sarcoma and pneumocystic carnnii (pneumonia) in previously healthy people. That was the year the formal tracking (surveillance) of AIDS cases began in the United States of America.

However, scholars claimed that the ultimate source of HIV/AIDS was the Sub-Saharan African continent. It is said that this region continues to be deeply ravaged by the disease. Bankole & Singh(2004) confirmed the above statement and added that Sub-Saharan Africa has been more devasted by the HIV/AIDS epidemic than any other region of the world. Garland (2003) presented explanation of the HIV/AIDS acronym thus:

H – Stands for Human – the Virus is only found in humans; it is not found in animals or insects.

I – Stands for immuno deficiency: this means, the virus reduces the immune system. White blood cells in the blood are part of the immune system. They are the soldiers that attack germs that enter the body.

V – Stands for Virus: This means that they are the smallest of all micro-organisms and hundred of times smaller than a bacterium or malaria parasite.

The Acquired Immune Deficiency Syndrome (AIDS) is the final stage of the disease. It continues in the human body till death. It can be explained thus:

A – Stands for Acquired: this indicates that its victims did not inherit it.

I&D- Stand for Immune Deficiency respectively: this shows that its victims have a common characteristic of a breakdown in their body immunity.

S – Stands for syndrome: It covers the case of rare but ravaging diseases that take defences.

Raen (1993) on the other hand stated that the disease is a syndrome because it consists of several signs and symptoms. Both mean the same as the signs and symptoms are as a result of the different kinds of diseases that attack the body.

HIV is said to attack the body defences (white blood cells) especially the type called CD4 cells which are like the coordinators of the immune system where they serve as eyes and ears or rather telephone of the body's army. Garland (2003) stated that the HIV virus attaches itself to the cell and later penetrates into it. Having entered the CD4 cell, it quickly multiplies by using the cells' own production "factories" to make copies of itself, and eventually kill the CD4 cells. The CD4 working in the body of a healthy person is supposed to be between 650 and 1250. When a person's count drops below 200, the person is said to have AIDS, but when the count drops to about 350, doctors usually prescribe some anti-retroviral drug therapy. When the CD4 cells are destroyed, the whole immune system does not work in harmony; this allows many different infections to enter the body and destroy it.

Ahmadu (1977) stated that there are two genetically and immunologically distinct human deficiency viruses, which have been discovered as causing HIV/AIDS disease. These are HIV – 1 and HIV – 2 which remain the dominant virus associated with AIDS in West Africa. An increasing number of different strains of both HIV – 1 and HIV – 2 are identified by molecular virology and by phenotype in cells culture. This increase is due to minor differences in the molecular structure of the virus.

Ahmadu (1997) added that HIV is capable of altering its antigens composition or its structure to avoid immune destruction and so continues to weaken the infected person's immunity. Therefore, HIV virus is cunning, crafty and deceiving, even to the body's immune system.

Raen (1993) described the HIV/AIDS virus as a gang of robbers which attack the human system. The virus has so many strategies that it adopts, that makes it widespread. When it enters the body, it starts fighting the white blood cells (lymphocytes: CD4 or T4) which normally protects the body against diseases or germs. The infected person can look and feel very well for many years. It can take 5 to 10 years or even longer and during that period of silence, the infected person can easily infect other people without knowing.

2.1.2 Causes of HIV/AIDS

HIV/AIDS is caused by infection with the human immunodeficiency virus (HIV). HIV/AIDS is most often contracted through sexual contact. Any person who engages in sexual activity, including vaginal, oral, or anal sex, can contract and pass on an HIV infection. This includes heterosexual, homosexual, and bisexual men and women. The more sexual partners a person has, the greater the risk of catching and passing on HIV/AIDS (http://www.bettermedicine.com/article/hiv-aids)

Effects of HIV/AIDS

AIDS is a deadly disease caused by a virus. The virus infects the human body and causes serious damage to the body's immune system by destroying the defensive mechanism of the body (cells), which can fight against other diseases. Once it has destroyed most of the defence cells of the body, the body no longer fights other infections like tuberculosis, hepatitis, diarrhoea, and other cancers. The victim is vulnerable to any form of minor disease and therefore, the person develops full blown AIDS or successive illnesses and dies.

2.1.3 Spread of HIV/AIDS

The HIV/AIDS virus can be transmitted or spread from one person to the other through the following ways:- First having sex, (i.e. penetrative sexual contact through vaginal, oral or nasal) with an infected person. In Nigeria, about 85% of AIDS infection is through sexual intercourse with infected persons (NERDC, 1995).

Momoh (2004) added that sexual intercourse is the primary way of contacting HIV/AIDS because it involves the exchange of bodily fluid. Odey (2004) supported the above assertion by emphasizing that sex is the major mode of transmission of HIV/AIDS. In realisation of this mode of HIV/AIDS, scholars have recommended that people should keep only one sex partner. But if they must have sex with an irregular partner, condom should be used though the church, especially the Catholic Church highly forbids the use of condom.

Another major mode of the spread of HIV/AIDS is through contact with HIV infected blood and blood product such as semen, vaginal secretion, etc, through blood transfusion, the use of unsterilized needles, knives, blades, syringes etc. Daudu (2005) and Raen (1993) asserted that HIV/AIDDS is contracted through direct contact with blood infected by the virus through blood transfusion or through infected needles, razors, and instruments used for ear piercing, circumcision, barbing, traditional birth attendants, blood covenants, scarification (tribal marks) and careless handling of patients by health workers.

Mother to child transmission is another major way by which HIV is contracted. Raen (1993) and the AIDS Alliance in Nigeria (2000) stated that women with HIV/AIDS can transmit it to their babies while in the womb or during birth, though there is limited risk of infection through breast feeding. For this reason, breast feeding is recommended because the risk of death through diarrhoea from bottle feeding is still greater. Garland and Haan (2004) added that mother to child infection accounts for about 10% of total HIV infections which is approximately 3 out of every 10 children born to an infected mother.

Okpe (2005) stated that the risk of mother to child transmission (M.T.C.F) of HIV varied from one country to another. But it is generally thought to be between 15 and 45%. An HIV infected mother in a developing country faces a higher (25-45%) risk of giving birth to a child who is infected. Okpe also added that prolonged breast feeding adds a risk of 15% or more depending on duration and other factors that scientists are still trying to determine. However, the danger of mother to child transmission is less when HIV positive women exclusively breast feed for the first six months. The risk is however higher with mixed feeding and complications developing from poor breast feeding techniques, especially in cases where the mother has mastitis or cracked and breast nipples. The risk also increases the more when the mother becomes infected with HIV while breast feeding as the viral load in the initial stage of infection is very high. Based on current available figures, Okpe (2005) concluded that without treatment, HIV positive women have an estimated 70% chances of giving birth to a healthy child. This means that up to ⅓ of children born to HIV positive women may be infected with HIV by implication. It means that infected breast feeding mothers should be encouraged to exclusively breast feed their babies for the first 6 months after which they can stop.

2.1.4 Symptoms of HIV/AIDS

Usually, early infection of HIV/AIDS is not noticeable immediately. In most cases, a few months or years (6 months to 12 years) is the incubation period. The period before an individual contacts HIV and when the infection develops to AIDS depends on the defence mechanism (body cell) of the person. There are two categories of AIDS symptoms, minor and major.

The minor signs of HIV/AIDS include the following:

- Cough for more than one month.
- Shortness of breadth
- Itching rash
- Swollen glands at two or more sites, e.g. in the area under the arm-groin.

- Thrush in the mouth and throat.
- Thick white coating on the tongue or throat.
- Tiredness even when the person has done no work
- Consistent headache.

The major sign of HIV/AIDS includes:

- Weight loss – there will be a progressive weight loss of more than 10% of body weight.
- Fever – unexplained or recurrent fever or night sweats for more than one month.
- Diarrhoea – on a continuous or intermittent form for more than one month. However, a person is diagnosed as having AIDS if he or she has one major sign plus two minor signs.

2.1.5 Prevention of HIV/AIDS

According to Awake (2004), there is no confirmed medical cure for HIV/AIDS. At the moment, some drugs called ANTI-RETROVIRAL are on production to fight this deadly disease (AIDS). But these drugs (ANTI-RETROVIRAL) only stop the virus from multiplying but no drug, to date is able to permanently destroy the virus inside the human body. The effective preventive measures against HIV/AIDS are as follows:

- Total abstinence from sexual intercourse with casual partners.
- Being faithful to one’s sex partner by maintaining a single partner.
- Avoiding pre-marital sex.

- Insisting on using new sterilized sharp objects such as needle and syringe during injection, immunization and circumcision. This also applies to blades and clippers which must not be shared with anyone to avoid blood contact.
- Avoiding contact with infected blood and blood products and receiving only screened blood for HIV/AIDS before transfusion during sickness.
- Using condom of approved quality. This becomes a necessity if one cannot avoid sex (intercourse) especially with strangers or if one has more than one sex partner.
- By avoiding behaviours that are likely to put one at risk of infection e.g. drug taking, being drunk and cult membership.

2.1.6 Things that Cannot Lead to Contacting HIV/AIDS

According to Ehizouwa (2011), the following behaviours cannot lead to HIV transmission. These include, shaking hands, hugging, touching an infected person, or casual kissing. Similarly, sleeping on the same bed or eating together cannot transmit HIV/AIDS. In addition, working in the same office, attending the same school and class, sharing cutleries (knives, forks, spoons), clothes and sharing the same toilet as well as swimming together in the same swimming pool do not spread HIV.

2.2 The Concept of Guidance and Counselling

The concept of guidance and counselling could mean different things to different people depending on the context within which they are used. For example, guidance in everyday language always connotes some form of help given to an individual or a group of individuals in areas like personal, social (giving information, direction and advice) education and vocation. Sambo (2008), Shertzer & Stone (1986) put it that guidance is to direct, pilot or guide. Guidance can be assistance given to people in different ways like helping someone in taking decision in life. Guidance therefore is a directing and piloting assistance.

The above definition of guidance is termed by Shertzer & Stone (1986) as a "layman's" or unprofessional definition. Arbuckle, Peter and Farewell as quoted in Shertzer and Stone (1986) clarified the term by pointing out the distinctive features implicit in the word. These distinctions arise when guidance is used as a:

(a) Concept (mental image)

(b) An educational construct (intellectual synthesis)

(c) Service (actions taken to meet a demand)

As a concept, guidance denotes the utilization of a point of view in order to help pupils understand themselves, and as a service, it refers to the procedures and processes organized to achieve a helping relationship.

The concept of counselling denotes a wide range of procedures including advice giving, encouragement, information giving, test interpretation and psychoanalysis. English and English (1966) defined counselling "as relationship in which one person endeavours to help another to understand and solve his adjustment problems". They pointed out that:

(1) Areas of adjustment are often indicated (example, educational counselling, vocational counselling, personal social counselling).

(2) Reference is usually to "helping" normal counsellee but creeps imperceptibly into the fields of psychotherapy, and

(3) While everyone occasionally undertakes counselling, the word is preferably restricted to professionally trained persons.

Gesinde, in Kolo (1997) viewed the term counselling as “an indepth interaction between two individuals with the intent of assisting the client to better understand himself in relationship to his or her present and future problems”. It is to be noted that out of the guidance services, counselling has been singled out as the basis for both guidance services and the counselling programme. This is because counselling is more crucial to one’s understanding of himself and also the world around him. This concept of counselling has been defined variously. Among the definitions are those of Wolfe (1987) who said that counselling is about helping people to help themselves to live their lives more effectively. Ivey (1980) also defined counselling as the “process concerned with assisting normal people to achieve their goals, or functions effectively”.

In counselling, the client’s emotion and feelings are of serious concern. It is because of the counselling service involved in guidance programme that has made many writers to define guidance as the assistance given to the individual to help them understand themselves, their world and to make intelligent adjustments and choices (Alao, 1981, Rao, 1981, and Shertzer and Stone, 1976). Thus, counselling focuses basically on areas of nurturing and healing emotionally, problem management, decision making, crisis management, support and life skills training.

2.3 The Concept of Adolescents

Adolescence is a period of transition between childhood and adulthood that involves biological, cognitive and socio-emotional changes. A key task of adolescence is preparation for adulthood. Indeed, the future of any culture depends on how effective this preparation is (Lawson, 2000). Although the age range of the period of adolescence can vary with culture and historical circumstances. In most cultures, adolescence begins at approximately 10-13 years of age and ends between the ages of about 18-22 (Lawson and Sarigiani,2003).

Adolescence is one of the most fascinating and complex transitions in the life span of man; a time of accelerated growth and change second only to infancy. Adolescence can also be seen as a time of expanding horizons, self-discovery and emerging independence; a time of metamorphosis from childhood to adulthood. Adolescents are unquestionably at a vulnerable developmental stage as they attempt to navigate the difficult transitions from childhood to adulthood (Carnegie Council of New York, 1992).

Most young people manage this transformation successfully, but many do experience major stress and find themselves engaging in behaviours that place their well-being at risk. More recent writers however, have taken exception to these assumptions. Rather than being the subject of uncontrolled biological impulses, stress and tumult, the vast majority of adolescents fare quite well; only a minority fit the more classic description of “storm and stress” (Gadsby, 2000). It is still correct to assert that there remains a sub group that experiences storm and stress, whose transition to adulthood is marked by turmoil and trial. For instance, only the non perceptive observer will be unaware of the upsurge of teenage pregnancy, venereal diseases and AIDS, as well as the rising pattern of violence, cultism, drug and alcohol abuse, school dropouts, and delinquency in most countries in Africa. For the sub group, adolescence is an extended period of struggle. During this period of stress and tumult, the ability to draw on effective adaptive coping behaviours is taxed. The resulting maladaptive behaviour risk affects the physical, psychological or social health of the adolescents.

2.3.1 Adolescents' Ignorance of HIV/AIDS

In many African societies, where guidance and counselling has been the onus of the family, sexuality education has been a way of bringing up children in culturally healthy and traditional way till the young people have been married.

In the cultural society in Nigeria, sex organs are rarely mentioned. Ohale (1999) argued that sex education is better unveiled to children through the right persons such as the parents and the teachers than for such children to learn about sex from peers and blue films. According to him, the consequences of the adolescent having the knowledge of sexuality education from the other unauthorized sources are more grievous than formal and organized curriculum.

Sexuality education and counselling programmes have been implemented in some states of Nigeria for example, Benue State. However, there have been questions from parents, teachers, and even students themselves as to whether such programmes have been effective in reducing cases of sexual ignorance or HIV/AIDS and STDS among the recipients. Aba (2003) asserted that guidance from the school administrators, teachers, counsellors and the media indicated doubt about the effectiveness and efficiency of guidance and counselling services and the instructional strategies that have been dispensing the programme in the state.

Researches by Awai (2003) and Momoh (2004) indicated that a good number of the recipients of sexuality education counselling programme manifested negative sexual and moral behaviour in schools and outside the schools.

The moral decadence in both urban and rural schools indicative of a general decline of morality in the society. This result shows the worrisome level of ignorance about the knowledge of HIV/AIDS and STDS among adolescents.

Rape and prostitution among the youths leading to child abandonment, unprepared marriages due to illegal pregnancies and school-drop-outs are very high among the female students. Furthermore, abortion with its consequences such as death, infertility and poor school attendance are rampant among the youths pointing to their ignorance of HIV/AIDS and STDS.

In addition to the foregoing manifest ignorance among the youths are overtly sexual practices, indecent dressings and high prevalence rate of HIV/AIDS and STDS. Awai (2003), in his findings recorded 13.5% of the subjects covered in his study in Benue State who had been infected with the scourge. According to this source, the state of adolescent health care in Benue State is a matter of concern.

Moreover, there is a downward trend in societal norms and values. The records of sexual ignorance and its repercussions from a series of ugly trends in schools within the past few decades require a re-examination of sexuality education counselling programme.

2.3.2 Teaching Sexuality Education in School

The concept of sexuality education is as chronicle as the dawn of man. It has been defined and explained by various authors; each writer has defined it as he perceived it from the point of view of his discipline. Akpan (1984) opined that some critics defined it as the actual mechanism in sexual activities. Ochai (2003) defined the concept as: the entire knowledge of the advantages and disadvantages one can derive from one's sexual relationship with one's sexual partner. Ochai did not however focus on the ideas of family planning, procreation, population policies and all other odds that have been embodied in sexuality education programme. Benedict (2004) explained that sexuality education is a way of curtailing sexual excesses in the active population and thus curtailing population growth in the country. He added that it entails the physiology of the reproductive organs and teaching the youngsters about the various acts of sexual intercourse, and its implications which might be negative or positive. It also involves the attainment of life satisfaction, in sexual relationship between legitimate couples.

In teaching sexuality education, it should be seen as a necessary step towards curbing the current scourge of HIV/AIDS and STDS. Sexuality education does not only relate to physical satisfaction, but rather, goes beyond the mere genital expression of affection. It is aimed at life-long satisfaction which prevents suspicion between couples and sexual partners. Federal Republic of Nigeria (2004) likened it to English language, Mathematics, Health Education, and Social Studies which are given precedence as core courses in the secondary schools. Sexuality education that is concerned with Adolescent Reproductive Health Care (ARHC) problems requires similar recognition like those core subjects. The justification of the inclusion of sexuality education in the school has been based on the areas of coverage which it embraces. Olayinka (1986) conceded that students need sexuality education at various levels of their educational development, because the frustration resulting from the adolescent reproductive health problems which the teenagers may encounter are enormous. Counselling is very essential for adolescents in order to make them understand themselves and their potentials.

Teaching sexuality education will enhance the proper rejuvenation of adolescents as defined by World Health Organisation (1999) as youths between 10 and 24 years who are transiting from stress and storms. At this stage, the adolescents have rapidly developing reproductive organs and all essential organs of their bodies which make the youngsters to have various urges which sexuality education can help control.

2.4 Theoretical Framework

Model and paradigms according to Doka (1995) have great values in the field of thanatology for both theoretical and clinical response. From a theoretical stand point, models are necessary since they allow an area to organize knowledge and to direct, organize and interpret research. He emphasized that models are clinically useful guides for practices.

Philips (1991) posited that models help in interventions to promote change in behaviour and for reducing the risk of future illness. Such efforts should be based upon theoretical models that identify the determinants of beliefs and attitude change. Many models pay attention to the importance of socio-cognitive factors in preventive and curative health. Some of these are health belief model of personal choice, health behaviour model, task model, and the causal model for testing counsellors burn out. They also include Mcabee's theoretical model, Germ theory and multiple causality models. They emphasize the individual 's power to decide without being forced to do so as central to all these models.

The health belief model was initially developed in the mid- 1950s and is perhaps one of the long-lived paradigms that attempts to identify and critically evaluate the factors responsible for human behaviour as they relate to an individual's health. Levin (1951) stressed that the model is strongly oriented towards the individual's personal perceptions of the world and how they motivate people's behaviour. Furthermore, he stressed that the model emphasizes motivation and the perspective of the individual based on his or her prior experience.

Rosenstock (1974) emphasized that they focused on the prevention of disease rather than its control. Discussing on the model, Galli (1978) perceived that threats to health are a person's perceived vulnerability to threats and the cost benefits pay off that is associated with adopting attitudes. He further explained that in life situation, individuals are pulled towards the forces that are positively valued and away from those that are negative. The model proves that an individual perceives himself or herself to be vulnerable to HIV/AIDS and believes that the disease is a terminal illness and feels better to change his feeling and behaviour than die of HIV/AIDS.

The individual is likely to adopt eating balance diet. In addition, a counsellor that perceives a youth vulnerable to HIV/AIDS and feels that the disease has no cure may decide to counsel the adolescents seriously based on knowledge experience.

Becher (1965) further posited that in reducing the problem of HIV/AIDS, gaining information on the disease and its treatment sharing experience with others in an atmosphere of mutual support is important. The use of counselling services is to clarify personal and emotional issues and developing ways of communicating effectively with counsellors. In addition, discussing with family members and friends is an example of a positive approach that can be taken in dealing with HIV/AIDS patients.

Pokes (1997) observed and expressed that the care of HIV/AIDS can evoke significant emotional stress in the counsellors and nurses who attend to the patients. Since members of the healing profession express delight and happiness with patients who get better, it is not surprising that the treatment of terminally ill people can result in the nurses and counsellors feeling anxious, frustrated and guilty. These feelings may be openly acknowledged or more correctly expressed through behaviour formation. The resulting stress responses may in-turn affect patients' care and staff relations as well as nurses mental and physical health and family relationships.

To help in caring for HIV/AIDS patients, Vernvert (1986) posited that one of the ideal goals should be to allay the physical suffering of patients as best as can and also help them prepare for recognition and acceptance of death. That way they can undertake their last task in life with credit and dignity. In other words, the presence of a counsellor and other care givers can bring comfort and reduce anxiety. The care givers of whom the counsellor is one, have the responsibility to structure schedules and surroundings so that patients have a sense of security and control over life and their environment.

The personal choice-model as stressed by Horn (1976) is that an unhealthy behaviour might be a means by which some individuals deal with various life situations and thus, is a psychological mechanism. This helps individuals to cope with circumstances. He explained that for such unhealthy behaviour to be changed, alternative psychological mechanisms must be developed and substituted to resolve all the contingencies of the problematic situations. This means, for example, a person may realize that obesity is not only unhealthy, but it is also unattractive. In addition, the threat of cardiovascular disease may be understood and accepted at a universal and personal level. Alternative action can be planned to alleviate the problem, but the unhealthy behaviour might have originated as a mechanism to cope with environment stress,

Commenting on this, Galli (1978) posited that the health care personnel model focuses on threat to an individuals health and does not recognize other forces that are influential in modifying health beliefs. They emphasized on the idea that the person must perceive a personal threat to his or her health if constructive measures are to be taken to avoid a health problem. Galli (1978) further explained that four conditions are necessary if the individual is going to engage in self protective behaviour. They include: being aware of the threat and accepting the importance of it; the threat must have personal meaning for the individual; the person must recognize that alternatives exist to alleviate the threatening situation and feel capable of altering his behaviour.

Finally, the personal-choice model concerns those factors that facilitate or inhibit continued reinforcement of a specific behaviour. He posited that television, radio, advertisement and peer pressure are factors that influence positively and negatively people's original behaviour.

2.5 Review of Previous Studies

Onuorah & Eze (2005) surveyed Nigerian youths' awareness of various modes of HIV/AIDS transmission and strategies for preventing its acquisition. Two research questions and two research hypotheses were raised to guide the study. The research questions were answered using mean, while the research hypotheses were tested using – test statistic at 0.05 level of confidence. The sample comprised 315 students of tertiary institutions in Enugu North Local Government Area of Enugu State. The findings showed, among others, that male and female students of tertiary institutions are to a great extent aware of the ways by which HIV/AIDS can be transmitted. A significant difference existed in their knowledge of the modes of transmitting HIV/AIDS virus. It was concluded that counsellors should organize group counselling sessions/workshops/ seminars/ conferences for students and parents to educate them on HIV/AIDS transmission and the relevant skills they need on HIV/AIDS prevention.

To obtain amore representative picture on HIV/AIDS among adolescents, Baba & Omotara (2001) said education remains one of the effective measures against HIV/AIDS infection. This study aimed at determining the sources of information of HIV/AIDS among the adolescents and to assess the effects of the information. The results showed that out of 354 respondents, 316 (89.3%) were informed about AIDS as an incurable and killer disease. Among those informed, 50.6% educated other family members on the disease. Television was the major source of information in all the schools studied. Friends/relatives and newspaper/magazines were also important sources. The effect of this information yielded positive reaction in only 26% of the respondents who opted for preventive measures. In addition, 84.8% of the respondents who had sex education were willing to avoid casual sexual relationship. Therefore, we assume that success in "vaccinating" the adolescents against AIDS through education programme could be attained when the correct message reaches the target population through the target's most preferred source of information.

Nnabueze (2000) investigated AIDS awareness among adolescents of Enugu State, using gender as a factor. This study was investigated using a survey research design. The research tool used for data collection was the questionnaire: Information was collected from a total of 2,000 respondents selected from the four tertiary institutions in Enugu State. Frequency and percentages were used to answer the two research questions. Chi square test was used to test the two hypotheses. Results showed that most of the undergraduate students of Enugu State tertiary institutions are aware of the Acquired Immune Deficiency Syndrome (AIDS). Their sources of information are more from the print media, their friends and peers than the electronic media, parents and elderly relatives. Considering the respondents' gender as a factor in this study, there was no difference in their responses, though more of the male respondents seemed to know about the causes of AIDS than their female counterparts.

Isaac and Olabode (2006) had a study on perception and attitude towards unprotected sex among students of Kwara State College of Education, Ilorin. A descriptive cross – sectional survey of 360 students, in a classroom setting was carried out, using a multi-stage and proportionate sampling technique to obtain 158 males and 222 females. The research tools were, a 6-item self administered structured questionnaire for students and an in-depth interview for the Director of Health Services. The response rate was very high at 96%. The findings revealed a preponderance of students perceiving unprotected sex as capable of promoting the increased incidence of HIV/AIDS in the community and a generally high tendency towards the practice of high risk behaviour among adolescents. However, a significantly greater number of males show this inclination ($p<0.05$). Reproductive health, particularly, sexuality education is currently, not on the school curricula and there is no policy on STI/ HIV/AIDS sensitization campaign in the school. Students' perception of unprotected sex did not influence their attitude towards the practice. It was recommended that the Nigeria Certificate in Education (NCE) curricula should include information on STI, HIV, AIDS and reproductive health.

Another study was conducted by Ogundara (2005) on wives' right to control husbands' sexual behaviour in response to the HIV/AIDS pandemic in Ekiti State. The study contended that if wives have the right to control their husbands' sexual behaviour, it could translate to a significant effort towards curtailing the spread of HIV/AIDS in Nigerian families. Quantitative data were gathered from a sample of 449 married couples in one urban and two rural locations in Ekiti State. Husbands' extra-marital sex was found to be high. Seventy-one percent of urban husbands, fifty-six percent of their wives and sixty eight percent of rural couples reported a high level of husbands' extra-marital sex for the study population. The universal assumption that wives have no right to comment upon, take note of, attempt to control and interfere in their husbands' extra-marital sexual activities is beginning to wane.

Although the control/comments/interference often takes the form of advise and admonition that is not binding on the husbands, that some of the husbands have been influenced by their wives' control shows that sexual behavioural change, which is largely significant in the effort to curtail the spread of HIV/AIDS is not impossible for men.

2.6 Summary

HIV/AIDS is a dreaded and devastating killer disease that has been plaguing the entire human race since it was reported in 1981. It is found in the body fluids especially blood, semen and vaginal secretions of infected persons. HIV/AIDS weakens the ability of an infected body's defence system to cope with infections by attacking and destroying the white blood cells which protect the body against diseases.

The knowledge of HIV/AIDS, peer support and education has been widely documented that behavioural change is most likely to occur if peers educate and support each other. A combination of counselling, education, support, care services, and resources is necessary to provide a holistic continuum of HIV/AIDS knowledge. From the foregoing, most of the work done on knowledge of HIV/AIDS among adolescents are Nigerian based.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research design, population, sample and sampling techniques. Other segments included instruments for data collection, validity of the instruments, reliability of the instruments, administration of instruments for data collection and procedures for data analysis.

3.1 Research Design

The research design for this study is survey in nature. Osuala (2005) explained that a survey research design studies both large and small population by selecting and studying samples drawn from the population. Considering the extensive nature of the population, it is quite clear that it is too large to handle or manage. For this reason, the researcher picked a sample from the population for easier and better management. Ekuafeh(2005) stated that the closer the population of a research work the more generalization power it has. Therefore, the survey research design was suitable and reliable in testing the facts for this study.

3.2 Population

The population for the study consisted of adolescents in some selected secondary schools in Zaria Metropolis. According to Kerlinger (1973), 10% of the target population is not too much or little for good research work. Based on the above author's view, 10% of any population can be used. Therefore 505 female and male adolescents were sampled for the present study.

Table 3.1 distribution of Respondent by Population

Strata	Male	Female	Total
Hallmark College	350	450	800
Therbow School	400	500	900
FCE Zaria Demonstration School	550	650	1200
St. Barth. Secondary school	600	750	1350
God's Time College	300	400	700
Total	2,850	2,200	5,050

3.3 Sample and Sampling Techniques

For the purpose of this study, a stratified random sampling was used. It is used in research where the researcher has some knowledge of the population under study. Nworgu (2002) stated that the research specifies the characteristics of the population or elements to be included in the sample in stratified sampling.

Table 3.2 Distribution respondent by sample

Strata	Sample size	Male	Female	Total
Hallmark College	80	35	45	80
Therbow School	105	45	60	105
FCE Zaria Demonstration School	120	55	65	120
St. Barth. Secondary school	130	50	80	130
God's Time College	70	20	50	70
Total	505	300	205	505

3.4 Instrumentation

The instrument used for data collection in this research was a structured questionnaire prepared by the researcher. The instrument constructed was to obtain relevant information from secondary school adolescents in Zaria metropolis on their knowledge of HIV/AIDS.

3.4.1 Description of instrument

The questionnaire consisted of five sections (A, B, C, D & E) Section A contained items on the bio-data of the respondents. It has items a and b, covering two areas of bio-data, namely, sex and age level. Section B sought information on the level of knowledge of the causes of HIV/AIDS. It is tagged 'causes of HIV/AIDS questionnaire(CHAQ)'.

Section C contained items on the behaviour that could lead to high risk of HIV/AIDS infections. It is tagged 'Behaviour that leads to HIV/AIDS questionnaire (BLHHAQ)'.

Section D contained items on the level of knowledge of the adolescents about the signs and symptoms of HIV/AIDS. It is tagged 'knowledge on signs and symptoms of HIV/AIDS questionnaire (ASSHAQ)'. Section E contained items on the preventive measures adopted by adolescents. It is tagged 'knowledge on preventive measure adolescent questionnaire(PMAQ)'. All the sections consisted of 10 items each, making a total of forty items except Section A, which had only two items.

3.4.2 Scoring of the instrument

A four-point rating scale was used to measure the subjects', responses as follows:

Strongly Agreed	(SA)	4
Agreed	(A)	3
Disagreed	(DA)	2
Strongly Disagreed	(SD)	1

For all positive statements, reverse is the case for all negative statements. Respondent to the adolescents' knowledge of HIV/AIDS instruments could score a maximum of forty (40) per section. This indicated a higher level of HIV/AIDS knowledge among adolescents. The least score of a respondent on HIV/AIDS knowledge of instruments is forty (40) which indicated low level of knowledge.

3.4.3 Validity of the Instruments

Having constructed the questionnaire with the stated items, the researcher ensured the validity of the content by checking the questionnaire item to make sure it tallied with the research questions and the hypotheses of the study. This check gave the research the assurance that the instrument truly measured accurately what it was intended to measure. The questionnaire was submitted to the thesis supervisors who made necessary corrections. A statistician was contacted for statistical analysis of the data. Having done that, the researcher ensured that all corrections were made in order to validate the research instrument.

3.4.4 Reliability of the Instruments

The reliability of the instruments was calculated using Split-Half (r) coefficient. Afolabi (1998) explained that reliability is the consistency and dependability of the instruments to measure what it was intended to measure when administered to similar testers twice or more. Pearson Product Moment Co-efficient Correlation was adopted to determine the reliability of instruments. The reliability estimate was calculated to be 0.67. This indicated that items were reliable within the acceptable limits. It further confirmed the assertion of Murherjee (2000) that the requirements for internal consistency were an average value of the correlation coefficient that must be pretty high around 0.67.

3.5 Pilot Study

A pilot study was conducted in order to test the reliability of the questionnaire. The pilot study was conducted before the main study in order to help check problem areas and possible confusion that may be associated with the study. The pilot study was carried out in Ahmadu Bello University Demonstration Secondary School, Kongo. A total of 30 respondents were given 30 questionnaires to respond to and return. In the analysis, the test for reliability of the instrument was carried out with the aid of the split Half method. The split-Half method yielded a reliability coefficient of 0.67. This estimate pointed to the fact that the instrument was reliable and internally consistent (Anastasi, 1980). It therefore means the instrument could be considered valid and reliable for the study.

3.6 Administration

The administration of the instrument and collection of data were done personally by the researcher and two research assistants who were trained by the researcher. The choice of this method of administration and collection was based on the need to achieve maximum return rate of the questionnaire. Having obtained permission from the Heads of selected schools, the researcher administered the questionnaire directly to the respondents.

Table 3.3 Data Frequency Table

	Frequency (%)		Frequency (%)
Questionnaire printed & administered	505(100%)	Questionnaire correctly filled	431(90.17%)
Questionnaire returned	478(94.7%)	Questionnaire wrongly filled	47(9.83)
Questionnaire not returned	27(5.3%)	Procedure for data analysis	

3.7 Procedure for Data Analysis

Data for the research questions 1-4 were analysed using statistical tools of frequency distribution and percentages, while data for research hypotheses 1-4 were analyzed using inferential statistics of independent t-test. The independent t-test statistics was used in this analysis because the set of data in the research are of interval scale of measurement i.e. continuous observations from a normal population and also comparing significant difference from two independent populations.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the data collected from the questionnaire administered to both male and female adolescents in selected secondary schools in Zaria metropolis. The data presented and analysed are based on the 431 copies of the questionnaire returned and the t-test statistical technique was employed to test the hypotheses measuring the difference between the male and female adolescents' knowledge of HIV/AIDS. The Null hypotheses were based on 0.5% level of significance.

4.1 Demographic Data

The sample population was made up of two groups of people, the female and the male adolescents in secondary schools in Zaria metropolis. The analysis is based on the respondents used as reflected on the 431 copies of the questionnaire returned.

4.1.1 Classification of Respondents by Sex and Age

Table 4.1: Classification of Respondents by Sex and Age

Variable	Frequency	Percentage
Sex		
Male	173	40.1
Female	238	55.2
No Response	020	4.7
Age Range		
10-12	39	9.0
13-15	177	41.1
16-18	178	41.3
No Response	37	3.6

The sex distribution of respondents table shows that 173 were male respondents while 238 were female respondents. This means that in this study, female respondents were more than male respondents, while classification of respondent by age shows that the age of respondents ranged between 10 and 18 but that respondents between 15 and 18 were more than those between age 10 and 12.

4.2 Research Questions

Question one: What is the knowledge level of HIV/AIDS among secondary schools adolescents in Zaria metropolis on the causes of HIV/AIDS ?

Table 4.2 Mean response of knowledge level on causes of HIV/AIDS.

S/N	Items	Mean	Std. Dev.
1	I am aware of the disease called HIV/AIDS	3.65	0.77
2	I believe that HIV/AIDS is real	3.57	0.74
3	I do not believe that sex is one of the ways of contacting the HIV/AIDS.	2.15	1.07
4	Practicing lesbianism and homosexuality can lead to infection with HIV/AIDS.	2.28	0.91
5	I do not believe that HIV/AIDS is one of the most deadly disease in the world today	2.30	1.13
6	HIV/AIDS cannot be contacted through sharing sharp objects like needles, razor blade with an infected person.	1.73	1.00
7	Transfusion of infected blood can lead to HIV/AIDS in the patient.	3.43	0.89
8	Sharing of clothes, towel and bed linen with an infected person can lead to HIV/AIDS infection	1.85	0.91
9	Mosquitoes can transmit HIV/AIDS in the same way they transmit malaria.	1.72	1.89
10	HIV/AIDS cannot be transmitted through kissing, hand shake and hugging.	2.77	1.04

It was observed that the means score, 3.65 for awareness of HIV/AIDS is higher than any other response. This is followed by the belief that HIV/AIDS is real and the least means score of 1.72 was on the transmission of HIV/AIDS by mosquito like malaria.

Question two: What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria metropolis on the behaviours that lead to high risk of HIV/AIDS infections?

Table 4.3 Mean response on knowledge level of the behaviours that lead to high risk of HIV/AIDS Infection

S/N	Items	Mean	Std. Dev.
1	Have more than one sexual partner	2.55	1.27
2	Have only one sexual partner	2.76	1.06
3	Hugging an infected person	2.30	1.05
4	Sleeping on the same bed with infected person	2.33	1.18
5	Shaking hands with infected person cannot lead to infection	3.10	1.09
6	Avoid casual sex	3.26	1.01
7	Avoid the use of unsterilized surgical instruments	3.45	0.79
8	Unprotected sexual intercourse	3.36	1.04
9	Unscreened blood transfusion	3.15	1.19
10	Oral sexual intercourse	3.13	1.10

The result on table 4.3 shows that the mean score of 3.45 for avoid the use of unsterilized surgical instruments' was higher than any other question and the least answered question was 'hugging an infected person' which has a score of 2.30.

Question three: What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria metropolis on the signs and symptoms of HIV/AIDS?

Table 4.4 : Mean response of Adolescent knowledge of the signs and symptoms of HIV/AIDS.

S/N	Items	Mean	Std. Dev.
1	Cough that lasts for more than one month	3.22	0.96
2	Feeling tired always	3.26	0.81
3	Diarrhoea on a continuous form for more than one month	3.42	0.96
4	Persistent head ache	3.10	0.84
5	Itching rash on the body	3.41	0.71
6	Shortness of breadth	3.19	0.84
7	Illness like tuberculosis, pneumonia and cancers may be experienced	3.38	0.75
8	Thrust in the mouth and throat	3.34	0.79
9	Infected person may have swollen glands	3.33	0.63
10	May have no signs and serious illness for a long time.	3.22	0.69

The results in table 4.4 shows that the mean score of 3.42 for diarrhoea was the highest while the mean score of 3.10 for persistent headache was the least.

Question four: What is the knowledge level of HIV/AIDS among secondary school adolescents in Zaria metropolis on the preventive measures to be used to reduce HIV/AIDS infection?

Table 4.5: Mean response of preventive measures of HIV/AIDS

S/N	Items	Mean	Std. Dev.
1	Be affectionate without sex	3.21	0.92
2	Don't have premarital sexual intercourse	3.22	0.86
3	Don't share needles, instruments or other things that might have blood on them.	3.63	0.55
4	Use a condom if you must have sex casually	3.20	0.94
5	Be faithful to one sexual partner.	3.46	0.77
6	Have regular HIV test if you cannot control yourself	3.33	0.69
7	Receive only screened blood	3.62	0.57
8	Avoid body contact with infected persons	2.04	0.91
9	For pleasure concentrate on oral sexual relation	2.19	1.04
10	Sex education should be introduced in upper primary and secondary schools	3.30	0.98

The results show that the mean score of 3.63 for the preventive measures of HIV/AIDS based on instrument is higher than any other preventive measure and the least mean score of 2.04 was for 'avoid body contact with infected person'.

4.3 Hypotheses Testing

Hypothesis one states that there is no significant difference in the mean response of male and female adolescents in the causes of HIV/AIDS.

Table 4.6: Result of t-test analysis of male and female adolescents on the knowledge of causes of HIV/AIDS.

Variable	N	$\overline{X}$	SD	SEM	t-value	t-Critical	P
Male	173	2.787	0.47	0.036	5.349	1.96	.000
Female	238	2.576	0.33	0.021			

The results show that the calculated t-value (5.349) is greater than the t-critical value (1.96) at 5% level of significance with a $p < 0.05$. Therefore, the null hypothesis of no significant difference in the mean response of male and female adolescents in the knowledge of the causes of HIV/AIDS is rejected and the alternative hypothesis is accepted. That is, there is a significant difference in the mean response of the knowledge of male and female adolescents in causes of HIV/AIDS. However, the mean response of the males is slightly higher than that of the female adolescents. This is an indication that the male have more knowledge of the HIV/AIDS than the female adolescents. This may be due to the fact that the males have more contact with people and that the culture of Northern Nigeria permits the male to have more exposure than the females.

Hypothesis Two states that there is no significant difference in the knowledge level of behaviour that leads to high risk of HIV/AIDS infections among male and female secondary school adolescents in Zaria Metropolis.

Table 4.7: Result of t-test analysis of male and female adolescent on the knowledge of behaviours that lead to high risk of HIV/AIDS infections.

Variable	N	$\overline{X}$	SD	SEM	t-value	t-Critical	P
Male	173	2.65	1.11	0.08	-1.94	1.96	.053
Female	238	2.82	0.68	0.04			

The results show that the absolute value of the calculated t (1.94) is greater than the t-critical value (1.96) at 5% level of significance with a $p < 0.05$. Therefore, the null hypothesis of no significant difference in the mean response of adolescent on behaviour that leads to high risk of HIV/AIDS infections is rejected and the alternative hypothesis is accepted. That is, there is a significant difference in the mean response of male and female adolescents on their knowledge of behaviour that leads to high risk of HIV/AIDS infection. The mean response of the female adolescents is higher than that of the male adolescents; this shows that the females have more knowledge of behaviour that leads to high risk of HIV/AIDS than the males.

Null hypothesis three states that there is no significant difference on the knowledge level on signs and symptoms of HIV/AIDS among male and female secondary school adolescents in Zaria metropolis.

Table 4.8: Result of t-test analysis of male and female adolescents on their knowledge of signs and symptoms of HIV/AIDS in Zaria metropolis.

Variable	N	$\bar{X}$	SD	SEM	t-value	t-Critical	P
Male	173	3.24	1.08	0.082	3.113	1.96	.002
Female	238	2.92	0.94	0.061			

The table shows that the calculated t-value (3.113) is greater than the t critical value (1.96) at 5% level of significance with a $p < 0.05$. As a result, the null hypothesis of no significant difference in the mean response of adolescents on signs and symptoms of HIV/AIDS is rejected and the alternative hypothesis is retained. That is, there is significant difference in the mean knowledge of male and female adolescents on signs and symptoms of HIV/AIDS in Zaria metropolis.

Null hypothesis four states that there is no significant difference on knowledge level on preventive measure to reduce HIV/AIDS among male and female secondary school adolescents in Zaria metropolis.

Table 4.9: Result of t-test analysis of male and female adolescents on their preventive measures to reduce HIV/AIDS in Zaria metropolis

Variable	N	$\overline{X}$	SD	SEM	t-value	t-Critical	P
Male	173	2.99	0.98	0.07	0.889	1.96	.374
Female	238	2.92	0.79	0.05			

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The above table shows that the calculated t-value (0.889) is less than the t-critical value (1.96) at 5% level of significance with a $p < 0.05$. Consequently, the null hypothesis of no significant difference in the mean response of adolescent on knowledge level on preventive measure to reduce HIV/AIDS is retained and the alternative hypothesis is rejected. That is, there is no significant difference in the mean perception of male and female adolescents in preventive measures adopted to reduce HIV/AIDS in Zaria metropolis. However, the mean response of the males is higher than that of the female adolescents; this is an indication that the male adolescents have a higher knowledge of preventive measures adopted to reduce HIV/AIDS in Zaria metropolis.

4.4 Summary of Major Findings

From the results of analysis presented above, the findings of this study are summarized on the basis of whether or not the items analysed were statistically significant or otherwise.

1. The analysis shows that there is significant difference in the mean responses of adolescents' knowledge of the causes of HIV/AIDS. The mean score of the male is higher than that of female adolescents.

2. It was discovered that the mean responses of the female adolescents were higher than those of the male adolescents. This shows that the female have more knowledge of behaviour that leads to high risk of HIV/AIDS infection than the male adolescents.
3. The study indicates that there is a significant difference in the knowledge of adolescents on signs and symptoms of HIV/AIDS in Zaria Metropolis. However the males' knowledge of the signs and symptoms of HIV/AIDS is lower than the female adolescents'.
4. It was established that the adolescents have a high knowledge of the preventive measures to use to reduce HIV/AIDS infections in Zaria Metropolis.

The research question was answered by comparing the male and female adolescents' knowledge of HIV/AIDS. It was observed that the mean scores of knowledge of HIV/AIDS is higher than for any other response, it is followed by the belief that HIV/AIDS is real and the least mean score is on the transmission of HIV/AIDS like malaria by mosquitoes.

The results showed that the mean score for the preventive measure of HIV/AIDS based on sharing of instruments is higher than for any other preventive measure, the mean scores for screened blood came second while the least mean score was the avoidance of body contact with infected person.

The answer to the questions showed that the score for the avoidance of the use of unsterilized surgical instrument was higher than any score for any other question. The least score was hugging an infected person.

It was observed that the mean scores of itching rashes on the body is higher than the score for other questions. It was followed by a score for illnesses like tuberculosis, pneumonia and cancers may be experienced while the mean scores for shortness of breath is the least.

4.5 Discussion of Results

This study set out mainly to investigate the knowledge of HIV/AIDS among the adolescents in Zaria metropolis. The results of the finding showed that there was significant difference between the male and female adolescents in their level of knowledge of the causes of HIV/AIDS. The mean responses of the male are higher than those of the female adolescents. This is an indication that the male adolescents have more knowledge of the causes of HIV/AIDS than the female adolescents. The result agrees with that of Nnabueze (2000) which investigated HIV/AIDS awareness among adolescents of Enugu State, using gender as a factor.

The result of the second hypothesis revealed that there was significant difference in the mean responses of adolescents on their knowledge of behaviour that leads to high risk of HIV/AIDS infection. Female adolescents' knowledge of behaviour that leads to high risk of HIV/AIDS infection is higher than that of their male counterparts. This result is in consonance with Isaac & Olabode's (2006) study on the perception and attitude towards unprotected sex among students in Kwara State. It revealed a preponderance of students perceiving unprotected sex as capable of promoting the increase in the incidence of HIV/AIDS in the community and generally high tendency towards the practice of higher risk behaviour among adolescents.

The third hypothesis revealed that there is a significant difference in the knowledge of adolescents on signs and symptoms of HIV/AIDS. It showed that male responses were higher than the female adolescents'. The result is in line with the result of

Nnabueze's (2000) on investigation of HIV/AIDS awareness among adolescents in Enugu State. In this study, there was no difference in the responses always gender lines. However, most of the respondents seemed to know more about the signs and symptoms of HIV/AIDS.

The fourth hypothesis raised revealed that there was no significant difference between the adolescents' knowledge on preventive measures adopted to reduce HIV/AIDS. This was buttressed by Onuorah & Eze (2005) survey on Nigerian youths' awareness of various modes of HIV/AIDS transmission and strategies for preventing its acquisition. The finding shows among others, that adolescents are to a great extent aware of the ways by which HIV/AIDS can be prevented.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter contains the summary of the findings, conclusions, recommendations and suggestions for further studies based on the findings of the study.

5.1 Summary

The major purpose of this study was to investigate the knowledge of HIV/AIDS among secondary school adolescents in Zaria metropolis. Among issues addressed were the general knowledge of HIV/AIDS outbreak among adolescents; the knowledge level on the preventive measures of HIV/AIDS, the behaviour that leads to high risk of HIV/AIDS infection; and the signs and symptoms of HIV/AIDS. Research questions were raised and hypotheses formulated for the study which facilitated meaningful results.

The methodology and procedure for data collection and analysis. It described the research design, population of the study, sample and sampling techniques, instrumentation, data collection procedure and data analysis based on the questionnaire administered.

Data were collected and analysed using independent t-test statistical tools to test the hypotheses, measuring the difference between the male and female adolescents' knowledge of HIV/AIDS.

The following findings were discovered in the investigation.

i. There was significant difference between the knowledge level of HIV/AIDS among male and female adolescents in Zaria Metropolis.

ii There was significant difference on the behaviour that leads to high risk of HIV/AIDS infection among secondary school adolescents in Zaria Metropolis.

iii. There was significant difference on the knowledge of signs and symptoms of HIV/AIDS among secondary school adolescents in Zaria Metropolis.

iv. There was no significant difference between the adolescents' knowledge on the preventive measures adopted to reduce HIV/AIDS among secondary school adolescents in Zaria Metropolis.

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5.2 Counselling Implications

From the findings and discussions of the study, the knowledge of HIV/AIDS differs amongst the adolescents, so counsellors should be employ the process of counselling adolescents. Since there is no significant difference among the adolescents in the preventive measure adopted to reduce HIV/AIDS, the counsellor should use the same counselling strategy in counselling both male and female adolescents.

It was observed that there was significant difference in the response of adolescents' knowledge of the behaviours that lead to high risk of HIV/AIDS infection. In offering counselling services, adolescents should be counselled to sustain their knowledge.

There is a significant difference in the knowledge of male and female adolescents on the signs and symptoms of HIV/AIDS. This implies that counsellors should take the difference into consideration when offering counselling to adolescents. In essence, both male and female adolescents need the services of the counsellor.

5.3 Conclusions

This research work on the knowledge of HIV/AIDS among secondary school adolescents in Zaria Metropolis, draws conclusions that adolescents in the research area generally, have the knowledge of HIV/AIDS. However, the analysis showed that the males have more knowledge of HIV/AIDS than their female counterparts. Therefore, the study recommends that counsellors should offer different counselling services for adolescents based on their gender and needs.

It was also established that adolescents have more knowledge of behaviours that lead to high risk of HIV/AIDS infection. It is necessary to educate the adolescents from time to time on the behaviours that lead to HIV/AIDS infection/acquisitions.

5.4 Recommendations

The problem of HIV/AIDS has reached a stage that it constitutes a serious public health concern in Nigeria. Following the findings on the knowledge level of HIV/AIDS among adolescents in Zaria metropolis, the adolescents should be exposed to sex and family life education as well as information about HIV/AIDS. This could be made available to students living in school, in their hostels, at home, libraries, public gatherings, places of worship and through the media.

It is recommended that curriculum experts in health education to incorporate concepts/topics on HIV/AIDS education in the contents of textbooks. There is the need to focus on preventive, and if possible, curative strategies. This can be achieved through proper AIDS education which will include the provision of accurate and up-to-date information on issues relating to HIV/AIDS.

There is also need to review the health education curriculum of those saddled with the responsibility of imparting knowledge to students. This would enable them to keep pace with current issues and problems in health. It is also essential to promote the use of condom during sexual intercourse among students. Parents and teachers should encourage students to imbibe the spirit of abstinence with regards to sex.

5.5 Suggestion for Further Study

Any researcher aiming at investigating similar research should look into social constraints of HIV/AIDS as it affects the status of the lives of the masses. Both the infected and non-infected persons are directly or indirectly affected by the effects of the virus. A study of control and prevention of spread of HIV/AIDS is suggested for further research.

5.6 Limitation of the Study

Time constraint and funding were limitations to the investigation and the results. Logistics and accessibility were limitations to the movement of the researcher and the administration of instruments for data collection, and retrieval of instrument.

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APPENDIX A

Letter to the Respondents

Dear Respondent,

Questionnaire on knowledge of HIV/AIDS

The research is aimed at finding the knowledge of HIV/AIDS among adolescents in Zaria metropolis. The researcher requests your assistance in filling the copy of the questionnaire given to you to the best of your knowledge and frankness. The research is purely on academic exercise which has nothing to do with priving into your privacy. Please do not write your name on the copy given to you, except you strongly feel otherwise. You are being assured that the information given by you will be treated with utmost confidentially.

Thanks for your anticipated cooperation.

Yours faithfully,

Williams, Nwanyinnaya Charity

Appendix B

QUESTIONNAIRE

General information

Please answer all questions freely, objectively and honestly. You are to indicate your response by ticking (√) or filling in the appropriate column or space provided to supply the required information. I still want to assure you that maximum confidentiality and privacy is fully guaranteed.

Biodata

SECTION A: (Respondents Personal Data)

1. A. Sex: Male [ ] b. Female [ ]
2. Age range: (a) 10-12 [ ] (b) 13-15 [ ] (c) 16-19 [ ]

Instruction: Please indicate your agreement with each statement of the four point scale by ticking (√) in the appropriate column that represents your opinion. The abbreviations used in the column are explained as follows:

SA - means Strongly Agreed

A - means Agreed

D - means Disagreed

SD - means Strongly Disagreed

SECTION B. Level of knowledge of the causes

Please, tick the appropriate opinion that appears to you using the following format

(1) Strongly Agree (2) Agree (3) Disagree (4) Strongly Disagree

Appendix B 1 Questionnaire

S/N	**ITEMS**	**SA**	**A**	**D**	SD
1	I am aware of the disease called HIV/AIDS	**4**	**3**	**2**	**1**
2	I believe that HIV/AIDS is real				
3	I do not believe that sex is one of the ways of contacting the HIV/AIDS.				
4	Practicing lesbianism and homosexual can lead to infection with HIV/AIDS.				
5	I do not believe that HIV/AIDS is one of the most deadly disease in the world today				
6	HIV/AIDS cannot be contacted through sharing sharp objects like needles, razor blade with an infected person.				
7	Transfusion of infected blood can lead to HIV/AIDS in the patient.				
8	Sharing of clothes, towel and bed linen with an infected person can lead to HIV/AIDS infection				
9	Mosquitoes can transmit HIV/AIDS in the same way they transmit malaria.				
10	HIV/AIDS cannot be transmitted through kissing, hand shake and hugging.				

SECTION B2: Behaviour that leads to higher risk of infection

Please, tick as it applies to you.

(SA) Agreed (A) Disagree (D) Strongly Disagree (SD)

Appendix B2 Questionnaire

S/N	Items	SA	A	D	SD
11	Have more than one sexual partner	**4**	**3**	**2**	**1**
12	Have only one sexual partner				
13	Hugging an infected person				
14	Sleeping on the same bed with infected person				
15	Shaking hands with infected person cannot lead to infection				
16	Avoid casual sex				
17	Avoid use of unsterilized surgical instruments				
18	Unprotected sexual intercourse				
19	Unscreened blood transfusion				
20	Oral sexual intercourse				

SECTION B3: Knowledge on signs and symptoms of AIDS.

(SA) Agreed (A) Disagree (D) Strongly Disagree (SD)

Appendix B 3 Questionnaire

S/N	ITEMS	SA	A	D	SD
21	Cough that last for more than one month	**4**	**3**	**2**	**1**
22	Feeling tired always				
23	Diarrhea on a continuous form for more than one month				
24	Persistent head ache				
25	Itching rash on the body				
26	Shortness of breadth				
27	Illness like tuberculosis, pneumonia and cancers may be experienced				
28	Thrust in the mouth and throat				
29	Infected person may have swollen glands				
30	May have no signs and serious illness for a long time.				

SECTION B4. (Knowledge on preventive measures)

Please read carefully and mark as it applies to you. Strongly agreed (SA) Agreed (A) Disagree (D) Strongly Disagree (SD)

Appendix B 4 Questionnaire

S/N	**ITEMS**	**SA**	**A**	**D**	SD
31	Be affectionate without sex	**4**	**3**	**2**	**1**
32	Don't have premarital sexual intercourse				
33	Don't share needles, instruments or other things that might have blood on them.				
34	Use a condom if you must have sex casually				
35	Be faithful to one sexual partner.				
36	Have regular HIV test if you cannot control yourself				
37	Received only screened blood				
38	Avoid body contact with infected persons				
39	For pleasure concentrate on oral sexual relation				
40	Sex education should be introduced in upper primary and secondary schools				