AN ASSESSMENT OF THE KNOWLEDGE, ATTITUDE AND BELIEF ABOUT HIV/AIDS AMONG STUDENT'S IN TERTIARY INSTITUTION IN ZARIA

BY

BELLO YAHAYA BABAMBA
M.ED/EDUC/41560/04-05

A THESIS SUBMITTED TO THE POSTGRADUATE SCHOOL OF AHMADU BELLO UNIVERSITY ZARIA, IN PARTIAL FULFILMENT FOR THE AWARD OF MASTER DEGREE IN EDUCATIONAL PSYCHOLOGY

DEPARTMENT OF EDUCATION
FACULTY OF EDUCATION
AHMADU BELLO UNIVERSITY
ZARIA, NIGERIA

FEBRUARY 2010

DECLARATION

I hereby declare that this thesis titled “An assessment of the Knowledge, Attitude and Belief about HIV/AIDS among student’s in tertiary Institution in Zaria” leading to the award of the degree of Master in Educational Psychology has been written by me, and that it is a record and production of my own work. All quotations are indicated by quotation marks and the sources of information are dully acknowledged by means of references.

To the best of my knowledge, this thesis has never until now been presented either partially or wholly for any other degree nor is it concurrently submitted for any other degree.

---------- ----------

Bello Yahaya Bababmba Date

CERTIFICATION

This thesis entitled **"AN ASSESSMENT OF THE KNOWLEDGE, ATTITUDE AND BELIEF ABOUT HIV/AIDS AMONG STUDENT'S IN TERTIARY INSTITUTION IN ZARIA"** submitted by Bello Yahaya Babamba meets the regulations governing the award of Masters degree in Educational Psychology of Ahmadu Bello University Zaria, and is approved for its contribution to knowledge and literary presentation.

---------- ----------
Dr. (Mrs) A.I. Mohammed
Chairman, Supervisory Committee Date

---------- ----------
Dr. (Mrs) E. F. Adeniyi Date
Member, Supervisory Committee

---------- ----------
Dr. Sadiq Mohammed Date
Head of Department

---------- ----------
Prof. S.A. Nkom Date
Dean, Postgraduate School

DEDICATION

To the memory of Ahmad Bin Abubakar and to those living with HIV/AIDS as well as to those who died of the epidemics.

ACKNOWLEDGEMENT

My sincere thanks go to ALLAH (SWT), the Creator and Sustainer of the Universe, the Gracious, the Merciful, who has made it possible for me to carry out this study. The execution of a project of this nature and scope obviously demands the assistance and cooperation of many individuals and bodies.

I acknowledge very profoundly the untiring and all round support of my able supervisor Dr. (Mrs) A.I. Mohammed has offered. Her accessibility in giving feedback and her friendliness are all qualities I will live to appreciate.

My deep appreciation and thanks go to Dr. (Mrs) E.F. Adeniyi, for her outstanding supervisory role as a second supervisor. Her motherly encouragement and prompt response when needed are greatly appreciated. To other examiners, Prof. M. Balarabe, Dr. Umma Abdulwahid, and Dr. (Mrs) K. Mahmoud, I am equally grateful for their useful suggestion and scrutiny.

I am indebted to my other colleagues and friends who have helped to make this work a reality. They include Prof. A.S. Ahmed, Prof. Sulayman Umar, Dr. I. Inekwe, Alhaji Salisu Mohammed Toranke.

Special gratitude to my wife Aisha Indo Abubakar for her cooperation and motivation, which largely facilitated the success recorded in this work.

I am indebted to all whose works have been cited in or used as theoretical basis for this study. I will however, add that in a study of this nature, errors cannot be totally avoided. Therefore, in consonance with tradition, I alone, am responsible for any shortcoming that is found in this study.

ABSTRACT

The study was designed to assess the knowledge, attitude and belief of undergraduate students toward HIV/AIDS in Zaria Education Zone of Kaduna state. In order to effectively execute this study, six hypotheses were formulated. The significant level of 0.05 was adopted to reject or accepts the hypotheses. The sample size consisted of five hundred students who were drawn from the three tertiary institutions in Zaria Education Zone. Data that were collected were analysed. Statistical methods employed in analysing the data were One way analysis of variance (ANOVA), Pearson Product Moment Correlation Coefficient and t-test, table were used for the data analysis. Percentages, Frequencies and Distribution were all employed in the data analysis. A "Knowledge, Attitude and Belief Questionnaire (KABQ) was designed by the researcher to collect data. The study revealed that non-significant difference exists between male and female students, resident and non-resident students as well as married and unmarried students in their knowledge, attitude and belief toward HIV/AIDS. Also, significant difference exists between students in various academic levels and students from the three institutions understudy with regards to their knowledge, attitude and belief toward HIV/AIDS. The study also shows that there is a relationship between students' socio-economic status and their knowledge, attitude and belief toward HIV/AIDS. It was recommended that students' should take HIV/AIDS course and pass before graduating. This will give them sound information of the disease. School management should Mount Massive enlightens campaign; this would improve students' knowledge, attitude and belief toward HIV/AIDS. Government and Non Governmental Organizations (NGOs) should invest vigorously on education by way of providing scholarship and loans/grants to students', particularly those students' from low socio-economic status, to enable them become self reliant through Income Generating Activities (IGA) in order to alleviate poverty which is the major cause of HIV/AIDS transmissions.

LIST OF TABLES

TABLES

PAGE

3.1 Showing the selected institutions…… 62

3.2 Samples of respondents…… 63

4.1 Percentages of respondents…… …71

4.2 One way ANOVA showing the difference of various academic levels of students' knowledge, attitude and belief toward HIV/AIDS…….. 73

4.2.1 means separation test on the knowledge, attitude and belief of respondents on HIV/AIDS. Using scheffe procedure……..74

4.3 t-test analysis showing the difference between married and unmarried students' on the level of knowledge, attitude and belief toward HIV/AIDS…… 76

4.4 Inter-correlation matrix between knowledge of HIV, attitude belief as well as socio-economic status of students'……. 77

4.5 t-test analysis showing the significant difference between male and female students' on the level of knowledge, attitude and belief toward HIV/AIDS…….. 78

4.6 t-test analysis on the significant influence of students' place of residence with regards to knowledge, attitude and belief toward HIV/AIDS…… 79

4.7 Oneway Descriptive analysis of variance on students' from different institutions on their knowledge, attitude and belief toward HIV/AIDS……..80

4.7.1 Means separation test of the respondents from various various institutions on the knowledge, attitude and belief toward HIV/AIDS. Using the scheffe procedure……81

DEFINITION OF TERMS

Apathy: Showing no interest or concerned to the disease (HIV/AIDS)

Asymptomatic: This is a period where HIV will be spreading in the blood system of an individual who has contacted it before it finally manifest to AIDS.

Campus freedom: This is a state of students not being coerce or constrained by fate, necessity, circumstances in ones choices or action. It could also refer to students acting according to the dictates of their conscience and term it as a right.

Economic fabric: This refers to the structure of the state of economic status of individual, group or nation.

Epidemic: This is a state of a particular disease, affecting or tending to affect many persons within a community, area or region at one time. For example, many people are dying of HIV/AIDS, a degree felt to be excessive.

Pandemic: It is a situation where a disease is occurring over a wide geographic area and affecting all exceptionally high proportion of the population. For example, an outbreak of HIV/AIDS is in all part of the world.

Labour force: This refers to people who are willing and able to work, and those who are already working in a giving population

Socio-economic Status: This refers to social status and economic position of the home.

Symptomatology: The set of symptoms that are associated with a disease or that affect a patient.

TABLE OF CONTENTS

TITLE **PAGE**

TITLE PAGE……i

DECLARATION……ii

CERTIFICATION……iii

DEDICATION……..iv

ACKNOWLEDGEMENT……v

ABSTRACT……vi

LIST OF TABLE……..vii

OPERATIONAL DEFINITION OF TERMS…….....ix

TABLES OF CONTENT……..……xi

LIST OF APPENDICES……xiv

ABREVIATION……xv

CHAPTER ONE: INTRODUCTION

1.0 Background to the Study……..……1

1.1 Statement of the Problem… ……...3

1.2 Objectives of the Study……..…...4

1.3 Research Questions……..……...5

1.4 Research Hypotheses……..……6

1.5 Basic Assumptions……..……7

1.6 Significance of the Study…..……...7

1.7 Scope and Delimitation……..8

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.0 Introduction……....9

2.1 Historical Background……..9

2.2 Symptoms and Manifestation of HIV/AIDS……..23

2.3 Knowledge, Perception and Attitude toward HIV/AIDS…….28

2.4 Sexuality and HIV/AIDS……..35

2.5 Cultural Belief and HIV/AIDS……..39

2.6 Gender and Vulnerability to HIV/AID……43

2.7 Decision Making and HIV/AIDS……51

2.8 Factors Leading to HIV/AIDS……...53

2.9 Review Studies on HIV/AIDS……....56

2.10 Summary……58

CHAPTER THREE: METHODOLOGY

3.1 Introduction……..60

3.2 Research Design……...60

3.3 Population of the Study……61

3.4 Samples and Sampling Procedure……...63

3.5 Instrumentation……64

3.5.1 Validity……65

3.5.2 Pilot Study……66

3.5.3 Reliability……66

3.7 Procedure for Data Collection……....67

3.8 Data Analysis……68

CHAPTER FOUR: RESULT AND DISCUSSION

4.1 Introduction……..69
4.2 Hypotheses Testing……72
4.4 Summary of Findings……81
4.5 Discussion of the Results……83

CHAPTER FIVE:

5.1 Summary Conclusion and Recommendations……90
5.2 Summary…… ……90
5.3 Conclusion…… ……91
5.4 Recommendation…… ……..93
References……96
Appendices……..100

LIST OF APPENDICES

APPENDICES

1 Questionnaire for students……..100

2 Letter for Seeking Information from Record Office, A.B.U, Zaria...103

3 Letters of Introduction from Fac. of Educ. A.B.U, to N.B.P and F.C.E, Zaria……104

ABREVIATION

AIDS: Acquire Immune-Deficiency Syndrome

ARC: AIDS Related Complex

CIA: Criminal Investigation Agency

CSW: Commercial Sex Workers

DNA: Deoxyribo Nucleic Acid

HIV: Human Immune Virus

IGA: Income Generating Activities

KABQ: Knowledge, Attitude and Belief Questionnaire

ICTR: International Criminal Tribunal for Rwanda

ICRW: International Center for Research on Women

MTCT: Mother - To - Child Transmission

RNA: Ribo Nucleic Acid

SIV: Simian Immune-deficiency Virus

STD: Sexual Transmitted Disease

STI: Sexual Transmitted Infection

UNAIDS: United Nation for AIDS

UNDP: United Nation Development Program

VCU: Voluntary Counseling Unit

WHO: World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study:

For many years, there has been a great concern by the government of Nigeria on the future of the youth concerning Human Immune Virus and Acquired Immune-deficiency Syndrome (HIV/AIDS) and its related problems. HIV/AIDS pandemic is a huge scare, particularly in Africa and indeed Nigeria. However, what scare more are the apathy, indolence and indifference that some members of our society continue to show on the subject.

The rate at which it is increasing is very rapid and threatening. In fact, it presents the biggest health threat in this century. Lack of effective medication for the disease as at now is a threatening phenomenon to human race. According to the World Health Organization (1990), AIDS is ravaging the whole world. The number of full-blown AIDS cases in the world today is estimated at 2.3million.

Going by the World Health HIV/AIDS report (2000), it is on record that the youth age between 18-35 are the most vulnerable population hit by the HIV/AIDS pandemic and it' is these youths who are the leaders in the next generation. The continue demise of

the youths implies that Nigerians hope for the future is deeming. The first AIDS case recorded in Nigeria was in 1986, (FMOH, 2004). Since then the number of HIV/AIDS cases has grown exponentially. By June 1999, the Federal Ministry of Health (FMOH) recorded 26,276 AIDS cases. These passively reported cases represent only small fraction of the actual number of AIDS cases, most of which go unreported. According to Kuti (1988), many Nigerians have been tested positive to AIDS; he feared that the spread of the disease is mainly due to ignorance and unbelief. He went further to say that, lack of conviction of the existence of AIDS on the part of some Nigerians has even made the case worse. Ten thousand persons are being infected by AIDS annually in Africa, the rate at which this epidemic move now have been multiplied by another hundred, said Fakeye (1989) in Nigeria Medical Practitioner Journal reports. It is therefore obvious that Africa is the part of the world most seriously affected by the disease.

Over the years, HIV/AIDS has been causing daily agonies on humanity and threatening the future of the nation. It is against this background that this research was undertaken. The researcher's choice of undergraduate youths is not arbitrary; this is because AIDS is a disease to which youths are more susceptible. At this

stage, many undergraduate youths want to expose themselves sexually and enjoy what they considered' 'campus freedom' without adequate knowledge of the consequence of this disease when contacted.

1.2 Statement of the Problem

It has become obvious that conventional western attitudes towards sexuality and HIV/AIDS are inappropriate in the case of Africa, especially in proffering solution to the menace of the HIV/AIDS epidemic. One very important fact in the HIV/AIDS spread in Africa is the fact that unlike in Europe and America where the disease is known to be common among homosexuals and intravenous drug users, it is largely spread through heterosexual contacts and women are more vulnerable than men are. The extent to which prevailing gender relations exist shows that, it has not been adequately studied.

Tertiary institutions in Nigeria and world over are indeed tasked with the responsibility to train and prepare young professionals in various areas to give valuable contribution to the country's economic development. However, HIV/AIDS and it related diseases are having a devastating impact on the available qualified Nigerians. This shows apparently that the long-term

prospect is very bleak. New infection is increasing at an alarming rate. It is still the young ages 18-35 who are infected most (New Nigeria, 2004). This age group occupies the tertiary institutions of higher learning in every country, including Nigeria. In Zaria the situation is that of fear among the adults while the youths are adamant to all preventive measures proffered. Some of them do not even believe in the existence of the disease not to talk about the effects it would have on them. This possibly explains why AIDS has been regarded as a disease of the youths who constitute the work force in any society. The rate of sexual interaction observed by the researcher motivates him into assessing students' knowledge, attitude and belief toward HIV/AIDS.

1.3. Objectives of the Study

The following stated objectives of the study are to determine:

1. Various levels of academics concerning student's knowledge, attitude and belief toward HIV/AIDS.
2. The difference between married and unmarried students students on the level of knowledge, attitude and belief toward HIV/AIDS.
3. The relationship of socio-economic status of students and their knowledge, attitude and belief toward HIV/AIDS.

4. Gender difference on students' knowledge, attitude and belief towards HIV/AIDS.
5. Knowledge, attitude and belief of students' resident on campus and outside campus concerning HIV/AIDS.
6. Students' from different institution; in knowledge, attitude and belief towards HIV/AIDS.

1.4 Research Questions

1. Is there any significant difference on the various levels of academics with regards to students' knowledge, attitude and belief toward HIV/AIDS?
2. Does any difference exist between married and unmarried students level of knowledge, attitude and belief with regards to HIV/AIDS?
3. Is there any significant relationship between socio-economic status of students' and their knowledge, attitude and belief toward HIV/AIDS?
4. Does gender difference affect the level of knowledge, attitude and belief of students' toward HIV/AIDS?
5. Does place of residence influence knowledge, attitude and belief of students' on HIV/AIDS?

6. Do students' from different institution differ significantly in their knowledge, attitude and belief towards HIV/AIDS?

1.5 Research Hypotheses

1. There is no significant difference among students' of various level of academics (400L, 100L, HND II, OND I and NCE I) on their knowledge, attitude and belief toward HIV/AIDS.
2. There is no significant difference between married and unmarried student on the level of knowledge, attitude and belief toward HIV/AIDS.
3. There is no significant relationship between students socio-economic status and their knowledge, attitude and belief toward HIV/AIDS.
4. There is no significant difference between male and female students on the level of knowledge, attitude and belief toward HIV/AIDS.
5. There is no significant difference between residential and non-resident students, knowledge, attitude and belief toward HIV/AIDS.
6. Students' from different institution do not differ significantly in their knowledge, attitude and belief towards HIV/AIDS.

1.6 Basic Assumptions

In this study, it is assumed that:

1. The youth have not been adequately exposed to the knowledge of HIV/AIDS.
2. Students belief affects their attitude toward HIV/AIDS.
3. No gender differences toward HIV/AIDS exist.
4. There exists no difference of students' place of residence about knowledge, attitude and belief towards HIV/AIDS.

1.7 Significant of the Study

There is high prevalence of HIV/AIDS in our society and this is of great concern to the researchers, corporate organizations and government.

The study is significant because it hopes to provide data collected from the undergraduate youths themselves on what their beliefs are about the effects of the disease. The outcome of the investigation will provide parents counselors and health educators with the necessary data based information.

The study is also significant when considering the threatening; and danger posed by the spread of HIV virus on the population, and the daily agony it has brought on humanity in general and the labor force in particular.

Findings from this study will help change the ideas, attitudes and perception of the youths towards HIV/AIDS in our campuses. It can also be useful to planner, researchers for projection of the population. It can equally be of assistance to the University, government and Nigeria in general to find a lasting and best way of controlling the spread of this disease.

1.8 Scope and Delimitation

The study is essentially limited to undergraduate youths in three tertiary institutions in Zaria (Ahmadu Bello University, Federal College of Education and Nuhu Bamali Polytechnic). These three tertiary institutions are chosen because there is high concentration of the youths undergoing various academic pursuits; a true representation of what is expected will be gotten from them.

For several years, these tertiary institutions especially Ahmadu Bello University has served as a centre of learning for the northern region and indeed Nigeria as a whole. Over the years, people of different background from Nigeria have come to study in these institutions and some have permanently settled in Zaria. Hence, it has become very suitable place for some Nigerians in terms of adequate representations in all human endeavors.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction:

This chapter focuses on the aims and objectives for which this study is being conducted. It is summarized as follows:

2.1 Historical Background of HIV/AIDS

2.2 Symptoms and manifestation of AIDS

2.3 Knowledge, perception and attitude toward HIV/AIDS

2.4 Sexuality and HIV/AIDS

2.5 Cultural Belief and HIV/AIDS

2.6 Gender and Vulnerability to HIV/AIDS

2.7 Decision Making and HIV/AIDS

2.8 Factors Leading to HIV/AIDS

2.9 Review Study on HIV/AIDS

2.10 Summary

2.1 Historical Background of HIV/AIDS

The Acquired Immune-deficiency Syndrome (AIDS) is a fundamental problem, a cosmopolitan, transcontinental and therefore qualifies as a pandemic. There is no nation, community

or society without HIV/AIDS. It flourishes everywhere on this planet earth. These days, the epidemic has been a topical subject, where it originated is yet to be established, particularly where and when the pandemic began. The targeted populations are youths that are leaving in a smaller community into larger societies that could be agent of transmission of the disease. They are to be observed, studied, understood, educated and guided to become responsible adults. They are the nation's richest resources and guardians of our society into the future. Nevertheless, moral laxity in our society today, particularly among the youths poses a great danger to the nation. The moral laxity that our youths are exposed to makes them potential victim of the disease AIDS. AIDS has devastated the social and economic fabric of African societies and has made many youths an orphan. Although, donor agencies initially viewed the plight of these orphans as a short-term humanitarian disaster, they now acknowledge the long-term social consequences of African youths growing up without parental love and guidance. These youths form a large group of dysfunctional adults that could further destabilize societies already weakened by AIDS.

Despite the evidence that prevention programs are carried out in most parts of the world, the HIV/AIDS epidemic continues to grow. By 2005, the number of those infected had grown to more

than 40 million, double in 1995, with Africa accounting for more than 60 percent of the cumulative cases of HIV/AIDS infection worldwide (UNAIDS, 2005). Some researchers even believed that the youths are mostly infected in most parts of the world and that the situations at any time vary between regions and countries as well as within countries, states, provinces and districts. This is why it is important to carry out a research on the knowledge, attitude and belief of undergraduate youths toward the pandemic.

Again, the sexually active members of the population usually undertake heterosexual relations. In this case, young adults or youths are more involved in heterosexual relations than other members of the population'. Hence, this group becomes the ideal target of any AIDS prevention programmed. Moreover, one setting where this target group of young adults can be located is at the tertiary institutions.

The impact of HIV/AIDS is still not fully understood, particularly when the long term is considered. The epidemics come in successive waves. With the first wave being HIV infection, followed several years later by a wave of opportunistic diseases, and later still by a wave of AIDS illness and then death. The final wave affects societies and economies at various levels, from the families and community to the national and international levels.

According to Gordon and Klauda (1988) who stated that the earliest presumed cases of Human Immune Deficiency Virus was discovered in the blood tissue of a boy in United State of America who died in 1969 of illness which suggested immune deficiency. His store blood and tissue were found to contain anti-bodies to Human immune deficiency virus.

Another related study by freelance journalist, Curtis, 1992 in (Shabu, 1997), put forward the theory that AIDS was inadvertently caused in the late 1950's in the Belgian Congo by Hilary's researched on polio vaccine. Although subsequently retracted due to libel issues surrounding its claims. Again, the Rolling stone article encouraged another freelance journalist, Hooper, 1959 in (Shabu, 1997), in his own study on polio vaccine stated that HIV was discovered in the virus of chimpanzee, which was conducted in Africa. From Hooper's experiment, it is believed that HIV/AIDS originated from Africa, that an experimental oral polio vaccine prepared using chimpanzee kidney tissue was the route through which SIV (Simian Immunodeficiency Virus) mutated into HIV (Human Immunodeficiency Virus) and started the human AIDS epidemic. Although, HIV/AIDS was first recognized by scientists in the 1980s, it is thought to have first entered the human population early in the 20th Century in the region of Democratic Republic of

Congo. The virus probably originally jumped into humans after people came into contact with infected bush meat. SIV have been reported in other primates, including gorillas. However, this is still contestable and not generally acceptable. The key facts surrounding the origin of AIDS are currently unknown.

The Human Immune-deficiency virus (HIV) is a retrovirus, i.e. a group of virus that is still largely unknown. According to Fakeye, 2003 in (Shabu, 1997), HIV/AIDS was first discovered in American men in June 1981. Soon after, its devastating effect began to spread to other continents of the world. He further asserts that by June 1983, it was recognized in Africa. The escalation was like whirl fire with most hit countries of Central and East Africa.

In her observation, Meyer, 2001 in (Uwalaka, 2002), provided some historical background in line with that of Hooper (1959), noting that the earliest known case of HIV infection dates to 1959, found in Congolese serum and that the disease is thought to have originated in Africa, having been transferred from monkeys to humans. While acknowledging that there are some disputes about the diseases origins, Meyer emphasized that the preponderance of scientific evidence clearly points to an African origin and zoonosis. Whether the transfer occurred through mixture of blood through hunting or husbandry or is related to the

development of the polio vaccine (which involved monkeys) is not known. However, Meyer noted that there are two major strains of HIV (HIV-1 and HIV-2) and a variety of subtypes, so that a vaccine developed for example in the United States might not be useful in other regions. In the same vain, Neema, 2001 in (Uwalaka, 2002), view AIDS in Uganda, where the disease was first detected in 1981, and at that time it was attributed to witchcraft or unknown causes.

More sinister theories abound, especially on the internet. Did HIV develop accidentally or was it created deliberately, some people believe the virus is the result of biological experiments and created by cancer researchers under the auspices of a federally funded special cancer virus program in United State of America. Others contend that HIV as a deadly germ escaped from a secret CIA laboratory. Also, officials of the former Soviet Union once publicly claimed that Russian scientists had worked with a U.S army biological warfare unit to create the virus (New Nigeria, March 2007).

It has been generally accepted for years that HIV is probably a descendant of SIV (Simian Immune-deficiency Virus) because certain strains of HIV-1 and HIV-2, the two types of HIV are found in the world. In his article, in New Nigeria News paper, Bello (2007)

explained how a research team led by Paul Sharp of the UK's Nottingham University and Beatrice Hahn of the University of Alabama in Birmingham, made a dramatic discovery during the course of a ten year long study into the origins of the virus. They identified a strain of SIV nearly identical to HIV-1 in a frozen tissue specimen taken from a captive member of the sub-group chimpanzees known as pan troglodytes, common in West-Central Africa. They believe the specimen from a chimp who died at a U.S. Air force primate center in 1984 proved chimpanzees were the source of HIV-1 and that the virus must have eventually crossed species from chimp to humans. Further research suggested wild chimps had been infected simultaneously with two different SIVs that merged to form a third virus that could be passed on to other chimps and was capable of infecting humans and causing AIDS.

We are twenty five years into this pandemic, said Beatrice Hahn in an interview with the Associate press. "We don't have a cure, we don't have a vaccine, but we know where it came from". However, identifying the source of the HIV pandemic is still a mystery. If researchers can figure out how the virus infects these chimpanzees and why it does not appear to cause disease in such a similar genetics species, those answers may be useful to humans. No matter what scientists discover about HIV, some will

cling to the belief that it's a manufacture virus designed to annihilate people of Africa descent. Some may even thinks the World Health Organization triggered the AIDS pandemic through contaminated smallpox immunization program years ago.

Taking the argument further, Sweeney (1991), in his study, discovered that the virus that causes AIDS is of three types, HIV-1, HIV-2 and HIV-0. These three types of viruses are regionalized. It was observed that an anti-test to detect HIV-1 was discovered in 1984. The second type HIV-2, was also discovered in March 1986, and is mostly found in West Africa, but more recently also in South-East Asia. He stated that Nigeria carries both HIV-1 and HIV-2. A laboratory test that could detect HIV-2 was discovered and not readily available until 1989. In 1994, the discovery of HIV-0 was announced and it is found in a small number of people in Cameroon and Gabon. He concluded that the HIV-1 and HIV-2 seems to take much time before the full blown disease developed. This was supported by Gyado (1992), who observed that AIDS is a new viral disease in which the body's defense mechanisms are altered in such a way that uncommon infections can occur. Also, he stated that the HIV-1 show several signs and symptoms after destroying the immune system of the body and at that stage it has developed to full blown AIDS.

The Acquired Immune-deficiency Syndrome (AIDS) has killed more than 25 million people since it was first recognized in 1981, making it one of the most destructive epidemics in recorded history. Despite recent improved access to antiretroviral treatment and care in many regions of the world, UNAID and WHO (2005) in their survey have estimated that about 45.3 million people are living with HIV and that sub-sahara Africa has the highest number of infected people with HIV/AIDS. The epidemic is not homogeneous within region but some countries are more afflicted than others are. Even at the country level, there are wide variations in infection level between different areas.

The distribution of HIV/AIDS victims in Africa varies with occupation and sex. Laah (2003) in his study shows that the highest victims of HIV/AIDS are civil servant (male and female) between the ages of 15– 49 years. In the same vain UNAIDS (2005) found that the adult between the ages of 15 – 49 years has the highest prevalence of HIV in the sub-sahara Africa which varies within regions. Presently Southern Africa is the highest hit region with adult prevalence rate exceeding 20% in most countries in the region, and even 30% in Swaziland and Botswana. Eastern Africa also experience relatively high levels of prevalence with estimates above 10% in some countries. Although there are signs

that the pandemic is declining in this region, e.g. Uganda which previously recorded one of the highest prevalence rate on the continent has now reduced. In other places in Africa that is not difference.

Furthermore, Teka (1993) in Alutu (2005) reports that epidemiological survey conducted in Ethiopia since 1987, indicate that the prevalence of HIV infection seems to be increasing. This is also the situation in Tanzania, which is known to have reported the largest number of AIDS cases in any country of the world. West Africa on the other hand has been much less affected by the pandemic, several countries reportedly have prevalence rates around 2—3% and no country has yet rates above 10%, although in two of the regions most populous countries, Nigeria and cote d' ivoire, are between 5% and 7% of adults reported to have carried the virus.

However, in another report by Momodu (1998) in Alutu (2005) shows that in Nigeria, the exact number of people living with HIV/AIDS is not known, the Federal Ministry of Health had estimated that over two million Nigerians were infected with HIV by mid-1999. This number may be mere speculation given the fact that it is practically difficult to give accurate information on prevalence rate in Nigeria because like other developing countries,

under-reporting the result of management and logistics problems can hamper efficient data collection and analysis.

Moreover, Bentwich (1995) in the study of HIV/AIDS in sub-sahara Africa, found out that the difference in infection levels between women and men are most pronounced among young people aged 15 – 24 years. In this age group, there are 36 women living with HIV for every 10 men. He further stated that, the widespread prevalence of sexually transmitted diseases, the practice of scarification, transfusion and the poor state of hygiene and nutrition in Africa may all be facilitating factors in the transmission of HIV-1 in this region.

In addition, the World Health Organization (WHO, 2000) estimated that 25% of the units of blood transfused in Africa were not tested for HIV, and that 5—10% of HIV infections in Africa were transmitted via blood, poor economic condition leading to the use of dirty and infected needles in health care clinics and also lack of sex education has contributed to high rate of infections.

According to UNAID and WHO (2005), Middle East and North Africa estimate adult of 15 – 49 prevalence of HIV is 25,000 to 145,000. in this area, the routes of transmission of HIV is diverse, including paid sex, sex between men and injecting drug

used, while the young people of 15 to 24 years of age, 0.3% of women and 0.1% of men were living with HIV by the end of 2004.

However, In South and South-East Asia, the HIV prevalence is 290,000 to 740,000. This is small when compared with population size. The world body said, this sprawling region is not just vast but diverse, with the nature, pace and severity of HIV epidemics differing across the region, and that the Aids picture in South Asia remains dominated by the epidemic. In India, latest estimates show that about 5.1 million people are currently infected with HIV. The HIV epidemic in Asia largely concentrated in injecting drug users, men who have sex with men, sex workers, and client of sex workers and their immediate sexual partners. Under this region, AIDS seems to be under control in Thailand and Cambodia but new infections occur in those nations at a steady rate.

Considering the case of East Asia, the World Health Organization said the picture in this region is dominated by China, with HIV prevalent in all regions of China and that most of the current spread of HIV in China is through injecting drug use and paid sex. In the rural areas where large numbers of farmers, especially in Henam province who most at times participated in

unclean blood transfusions, estimates of those infected are in the tens of thousands.

In fact, the story is not different in Latin America, where the world body (WHO) said only Guatemala and Honduras has national HIV prevalence of over 1%, those HIV men outnumber HIV infected women by roughly 3:1. Drug injection and homosexual activity are the primary method of spreading the virus, however, Brazil recently began a comprehensive AIDS prevention and treatment programmed to keep AIDS in check, including the production of generic versions of anti-retroviral drugs.

For that of Caribbean, it has been observed by the world health body that it is the second most affected region in the world, and that AIDS has become the leading cause of death among adults age of 15 to 44. It is believed that HIV transmission occurs largely through heterosexual intercourse, with two thirds of transmission, even though it is heavily stigmatized and illegal in many areas of the region. Infact, HIV transmission through injecting drug use remains rare, except in Bermuda and Puerto Rico.

In Eastern Europe and Central Asia, The world health body observes that the rate of HIV infections rose rapidly from the mid 1990's to 2005 due to social and economic collapse, increased

levels of intravenous drug use and increased numbers of prostitutes. There are predictions that the infection rate in Russia, Ukraine and Estonia will continue to rise since education about AIDS is almost non existent that is why by 2004 the numbers of reported cases was over 257,000. The epidemic is still in its early stages in this region, which means that prevention strategies may be able to halt and reverse this epidemic. However, transmission of HIV is increasing through sexual contact and drug use among the young of about 30 years. Indeed, over 80% of current infections occur in this region in people less than 30 years of age.

On the contrary, in western countries AIDS cases have fallen to levels not seen since the original outbreak, said the world health body. Many scholars attribute this trend to aggressive educational campaigns, screening of blood transfusions and increased use of condoms. In this area, the routes of transmission of HIV is diverse, including paid sex, sex between men, injecting drug use, mother to child and heterosexual sex. The adult (15 to 49 years) prevalence in this region is 0.3%, this is between 570,000 and 890,000 people currently living with HIV. Due to the availability of antiretroviral therapy, AIDS deaths have stayed low since 1990's. However, in some countries, a large share of HIV infections remain undiagnosed and there is worrying evidence of antiretroviral drug

resistance among some newly HIV infected individuals in this region.

For that of North America the world health body said, currently, rates of HIV infection occur most often on eastern and southern regions. The adult prevalence rate in this region is 0.7% with over one million people currently living with HIV. In united state, sex between men, heterosexual sex, and needle sharing by intravenous users remain prominent sources of new HIV infection. It is believed that 35,000 to 40,000 infections occur in the U.S.A every year. In general, just like in western countries the death rate from AIDS in North America has fallen sharply, as new AIDS therapies have proven to be an effective means of suppressing HIV.

Finally the world health body (UNDP) said there is a very large range of national situations regarding HIV/AIDS in the region of Oceania. This is due to the large distances between the Islands of Oceania. The prevalence is estimated at between 45,000 and 120,000 adults and children currently living with HIV.

2.2 Symptoms and Manifestation of AIDS

Many people do not develop any symptoms when they first became infected with HIV. In fact, the name AIDS applies only to

the last stage of HIV. At this stage there are a number of clear indicators which shows that the illness is certainly AIDS. The manifestation of HIV/AIDS varies widely in the world. According to week magazine (1987) in Shabu (1997) stated that some people pass through a first stage with fever and throat infection, they can then be without symptoms for a time period. This indicates that not all people show all these signs and symptoms before it reached the final stage of AIDS. The magazine further explains that some signs and symptoms are more common in certain parts than others e.g. slim disease, stress and weight loss is most common in Africa, while pneumonia is common in the United State of America.

In the publication of the Christian Medical Commission (1987), it reveals that some people pass through a first stage with fever and throat infection; they can then be without symptoms for a period. To them, before the final diagnosis can be made the person might have suffered from different symptoms of infection. They further said the infections are grouped into what is called AIDS Related Complex (ARC). That the manifestation of the disease varies widely in the world. The symptoms of AIDS may be there but the final diagnosis can only be made by testing.

According to UNAID/WHO (2007), many people do not develop any symptoms when they first become infected with HIV

virus but some people, however, get a flu-like illness within three to six weeks after exposure to the virus. The world body further stated that during this period, the quantity of the virus in the body will be high and it will spread to different parts of the body, particularly the lymphoid tissue. At this stage the infected person more likely to pass on the infection to others. The viral quantity then drops as the body's immune system launches an orchestrated attack. The world body said, though more persistent or severe symptoms may not surface for several years, even a decade or more. This is known as the asymptomatic period. The period of asymptomatic infection varies from individual to individual; some people may begin to have symptoms as soon as a few months, while others may be symptom-free for more than 10 years. However, during the asymptomatic period the virus will be actively multiplying, infecting, and killing cells of the immune system.

Likewise UNDP (2007) stated that once HIV enters the body, it attaches itself to White Blood Cell called CD4. They are the main disease fighters of the body. Whenever there is an infection CD4 cells lead the infection-fighting army of the body to protect it from falling sick. However the damage of this cell can affect a person disease-fighting capability and general health.

Going by the world body (UNDP), if the disease makes a foothold on the CD4 cell, the virus inject its RNA into the cell, it then gets attached to the DNA of the host cell and becomes part of the cells genetic material. It is a virtual take over of the cell. Using the cells division mechanism the virus now replicates and chunks out hundreds of thousands of its own copies. As a result, the number of the virus in the blood rises and that of the CD4 cells declines. After a few years which can last up to a decade or more, when the number of the virus in the body rises to a very high level, the body's immune mechanism finds it difficult to carry on with the battle, as such other opportunistic infection like Mycobacterium avium complex, Tuberculosis, Salmonellosis and Bacillary angiomat (caused by bacteria); Cytomegalovirus, Viral hepatitis, Herpes, Human papillomavirus and Progressive multifocal leukoencephalopathy (caused by virus); Candidiasis, Cryptosporidiosis meningitis and Pneumocystis pneumonia (caused by fungus); Toxoplasmosis and cryptosporidiosis (caused by parasites) will bring the individual down. In addition, HIV persons are also prone to cancers like kaposi's sarcoma and lymphoma.

The world body (UNDP) further gave a number of clinical indicators of full-blown AIDS. They are-

1. Lack of energy.
2. Weight loss, frequent fever and sweats.
3. Severe or recurring vaginal yeast infections.
4. Rapid loss of more than 10 pounds of weight that is not due to increased physical exercise or dieting, recurring or unusual skin rashes.
5. Bruising more easily than normal, deep and dry coughing.
6. Increasing shortness of breath.
7. Chronic pelvic inflammatory disease.
8. Thick-whitish coating of the tongue or mouth.
9. Period of extreme and unexplained fatigue that may combine with headaches, Lightheadedness and dizziness.
10. An altered state of consciousness, personality change or mental deterioration.
11. Severe numbness or pain in the hands or feet, the loss of muscle control and reflex, paralysis or loss of muscular strength.
12. Swelling or hardening of glands located in the throat, armpit or groin.

13. Long lasting bouts of diarrhea, Recurring or unusual ashes.
14. Unexplained bleeding from growths on the skin, from mucous membranes or from any opening in the body.
15. The appearance of discoloured or purplish growths on the skin or inside the mouth.
16. HIV positive persons are also found to be more vulnerable to cancers.

2.3 Knowledge, Perception and Attitude toward HIV/AIDS

Sofowole in THIS WEEK MAGAZINE (1987) opined that many people sees Aids more as a catalyst for a return of morality. However, youths and adolescents see AIDS campaigns as an extension of biblical propagation of morality and therefore do not take adequate measures and prevention serious; they have a false perception concerning the Human Immune deficiency Syndrome. He concluded that ‘it is the cure for flirtation’.

Onyemelukwe (1993) in Health waver (1995) said that even hospital workers are very much afraid of getting infected in their high risk set up. Despite this young people still have false perception concerning this disease (AIDS). Further, Onyemelukwe argues that most young people believe they are too young to

contact AIDS. However, considering the fact that they are old enough to have sex they therefore forget that they can equally contact HIV.

A young man was met saying ‘if he gets AIDS and die, that is his luck, he doesn’t need to spoil his young life by thinking about AIDS. That it is better for him to forget about AIDS and have good time as much as he can, that he has never seen an AIDS victim before and that every one will have to die one way or the other, (Sweeney, 1991). To another set of young individuals they are reluctant to have themselves tested; this uncertainty, therefore, increases their anxiety and suffering.

To ascertain the perception of students regarding the reality of the AIDS pandemic, Anugwom (2004) in his research on student’s perception of HIV/AIDS observed that students saw AIDS as not really in existence, that the respondents mostly see AIDS as part of the politics of developed and western nations using the pandemic to put Africa in place. He said this is worrisome when one pits this sort of revelation against the fact that the respondents are university students who are supposed to be very informed. All the same, the students have heard of the existence of the disease in Africa, even though they have not actually seen an AIDS patient before except on the television.

This revelation vindicates the contention of Raufu (1993) that Nigerians scoff at the idea of the reality of AIDS and see it as Western inspired propaganda. Such a perception of AIDS may not be unrelated to colonial experiences of Africans in which everything bad was attributed to the blacks by the whites, while the efforts of educated Africans to counteract such an orientation, particularly in the socio-political arena are commendable, its carry-over to a major health threatening situation is really a source of concern. Also this type of perception puts a big question mark on the effectiveness of AIDS enlightenment and prevention campaigns in Nigeria. As Cochran and Peplau (1989) rightly observed, the perception of being at risk is a factor in the change of attitude and behavior is germane to any sustainable AIDS prevention efforts.

In a bid to discover the coping ability of the respondents in case of rapid AIDS disaster, they were asked to classify death from AIDS either as un-natural or normal. This stems from the belief that those who see death from AIDS as normal may be in a better position to cope with its disaster than others. At the same time, those in this category may be less receptive of AIDS prevention messages. The result shows that 125 (31.3 percent) of the respondents see it as normal. The respondents that see

nothing abnormal in dying from AIDS were asked to state reason why they feel so. A majority in this category of respondents (38.2 percent) see death and cause of death as pre-ordained; 22.6 see death as either usual or see cause of death as unimportant.

In view of the fact that all the respondents have heard of the existence of AIDS in Africa and most of them have also heard of preventive messages or seen anti-AIDS posters, they were asked whether they took any form of precaution in their sex activities. The respondents, who are typical of Nigerian students, do not take the AIDS threat serious enough. It is disappointing that out of a sample of 400 students, 160 of them do not take any form of precaution against AIDS. This supports the argument of McPherson (1996) that simplistic messages and information alone is not adequate as such therefore, there is the need for effective intervention programmed.

It is against this background that this exploratory study discovered amongst others, that the AIDS perception of Nigerian students is ill-informed. Hence, they see AIDS as development propaganda; a significant number also see AIDS as not really in existence, and do not want to be bothered any form of precaution. Some of these discoveries are as insightful as they are disturbing. They seem to call for a realignment of AIDS prevention

programmes to tackle the problem of wrong or unjustified perception.

Perception that may be products of historical reality, environment and culture affect one's behavior and attitudes to the AIDS threat. Nigerian students who view western oriented programmes with suspicion are likely to see the AIDS threat as one more card in the trick bag of developed nations. This perception, earlier noted by Raufu (1993), needs to be tackled if meaningful results are to be achieved in prevention efforts.

Current statistics show that the HIV/AIDS epidemic in Nigeria has assumed alarming proportions. Those worst hit are age 15 to 49 years, and of whom about 2.6 million are already positive. In spite of the current efforts to reduce the rate of infection, many Nigerians do not appear to consider the epidemic a serious problem and are therefore not taking enough precautionary measures to avoid infections. According to Adedimegi (2004) some people still do not believe there is HIV/AIDS, hence its denial is widespread. He said, the reasons being that they have not seen an HIV/AIDS victim before or that they view the danger posed by HIV/AIDS fatalism, arguing that one will eventually "die of something", and so are not prepared to change their sexual behavior simply because of threat of HIV/AIDS.

In the light of the above argument so far, opinions remain mixed. While most adults tend to believe absolutely that AIDS is real, most youths tend to cast doubts on the existence of AIDS. However, the existence of AIDS patients and victims points clearly to the existence of the scourge called AIDS.

In Nigeria for instance, it has been reported that by 1987, majority of students sampled had already heard of HIV/AIDS. For example in a study conducted by Fabiyi (1993) in Obafemi Awolowo University, Ile-ife indicated that majority of the students heard of HIV/AIDS from newspapers and magazines for the first time in 1987, with only a handful of them reporting that they had heard of AIDS between 1982 and 1986.

Cok (2005) reported that university students have moderate level of knowledge about the transmission of symptomology and prevention of the disease, though, with a great deal of misconception regarding HIV/AIDS. Similarly, Singh (1997) report that although students were reasonably knowledgeable about the role of sexual contact, blood transfusion, infected needles and vertical transmission, they had misconceptions about the transmission of HIV through casual contact; as 57 percent respondents had thought that AIDS was preventable by vaccine, while 51 percent believe AIDS was curable. In the same vein, the

works of Okeke and Fortune (1992), revealed that, most students knew that HIV could be transmitted through vaginal, anal sex, blood transmission and by sharing needles with HIV infected drug users, while only few students knew that HIV cannot be transmitted by sharing clothing, sneezing and coughing, sharing of drinking glasses, shaking of hands, hugging, kissing, and from swimming pools.

The respondent in Buggaleys (1997) study was quite knowledgeable about transmission of HIV through semen, blood and virginal fluid. However, 50 percent of them believed that saliva transmits HIV. Similarly, Deshmukh and Harding (1999), reveal that their respondents were knowledgeable about transmission and symptomatology, but there were misconception about the mode of transmission. While the students were knowledgeable enough about contacting the disease from their partners, yet this did not prevent them from engaging in unprotected coitus. Conversely, Chakaraborty's (1996) survey of the awareness and attitude of HIV/AIDS among students living in India and their counterparts that had migrated from India to the US, reveal that majority of the participants in both groups felt that their knowledge was inadequate. The study of Ambit (1997) revealed that although there respondents were aware that sexual intercourse and

injecting drug use can transmit HIV, and shaking of hands and mosquito bites cannot transmit HIV; majority of the respondents did not also know that breast feeding is a mode of transmission.

2.4 Sexuality and HIV/AIDS

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics and roles. A social and cultural construct differentiates women from men and defines the ways in which women and men interact with each other. There is always a distinct difference between women and men's roles. Typically, men are seen as being responsible for the productive activities outside the home while women are expected to be responsible for reproductive and productive activities within the home.

Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes. It is more than sexual behavior; it is a multi-dimensional and dynamic concept. Moore (1996) in his investigation stated that explicit and implicit rules imposed by society, as defined by one's gender, age,

economic status, ethnicity and other factors influence an individual sexuality. Gupter (1998) observed the components of sexuality and came out with 6 Ps which he refers to as practices, partners, pleasure, pressure, procreation and pain. The first two refer to aspects of behavior how one has sex and with whom; while the other refers to underlying motives. Over the years, research studies have shown that there is an additional 'P' of sexuality, which is the most important, power. The power underlying any sexual interaction, heterosexual or homosexual, determines how all the other Ps of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place.

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women do over when, where, and how sex takes place. Research supported by ICRW and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women's sexual autonomy and expands

male sexual freedom, thereby increasing women's and men's risk to HIV/AIDS (Gupter, 1998).

Since the HIV/AIDS pandemic began more than 25 years ago, infection rates among women have accelerated when compared with men, (UNAIDS, 2002). Traditional gender roles held by many of the world's societies are largely responsible for the continued spread of HIV, particularly from men to women. In most societies, women also carry a disproportionate amount of caring for family members living with HIV/AIDS and the brunt of the stigma associated with HIV infection.

In industrialized countries, Soyinka (1998) in Laar (2003) stated that virtually all infections used to occur in men, but the scenario is now changing. Women comprised about 12% of the AIDS cases reported in France in 1985, 10 years later, this figure rose to around 20%. The Nobel prize winner also says that, in 1984, only one woman was infected for every 99 men, but today women account for a quarter of all those with HIV in Brazil. This shows that Brazilian women have probably experienced spectacular increase in the risk of HIV.

Reid (1998) in Laar (2003) observed that men and women alike are at risk of infection from HIV virus, yet in many ways, women are particularly vulnerable. The history of the epidemic in

the developed world has lured many women into a false sense of security since it emerged historically as a disease of women. It is never mentioned that men play the major role in prostitution. Friedill (1992) estimated that the proportion of prostitution to client is 1.5 to 98.5.

However, earlier studies of HIV/AIDS did not reveal significant differences in gender specific progression to AIDS. Kenneth (1992) reported a study of 139 women and 111 men in the United State and 253 infected women and 422 HIV infected men in Italy, there were no significant gender differences in the progression to AIDS. Matlin and Spence (2001), indicate that more women than men are now dying of HIV related causes. The changing patterns of HIV transmission mirror divergences linked to biology, sexual behaviors, social attitudes and pressures, and economic power and vulnerability. In their study, women are more vulnerable to HIV infection because of their lower social status disadvantages related to health-care access, education and employment.

2.5 Cultural Belief and HIV/AIDS

On the basis of the Mexico declaration of 1982, culture is broadly understood within UNESCO to include ways of life, traditions and beliefs, representation of health and disease, perception of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communication; as well as arts and creativity. From this definition, it is clear that culture influences attitudes and behaviors related to HIV/AIDS epidemic. In taking or not taking risk of contracting HIV, in accessing treatment and care, in shaping gender relations and roles that put women and men at risk of infection, in being supportive towards or discriminating against people living with HIV/AIDS and their families, etc.

Many cultures and religions give more freedom to men than to women; for example, in many cultures it is considered normal and sometimes encourage for young men to experiment sexually before marriage. Also, in many cultures, it is considered acceptable for men, even married men to have sex with sex workers. These cultural attitudes towards sex are leading to HIV infections in both men and women, often the men's wives. Because men traditionally seen as the providers, and they believe that they must fulfill this role, many of them react negatively if they

cannot find work or if they are unable to provide for their family. Men's sense of anger or disempowerment may lead to alcohol or drug abuse, violent behavior, increasing both their own and their partners' risk of HIV infection.

Employment opportunities for men may restore self-esteem and reduce their tendency to engage in such risky behavior. However, employment may also mean that couples have lived apart, since men must sometimes migrate or be mobile for work, as the case for long-distance truck drivers. Due to loneliness and the availability of money, these men may have unprotected sex with other women or men and become HIV infected. These HIV men may in turn infect their wives and other sexual partners.

Furthermore, there are certain beliefs in the form of cultural taboos and practices that help aggravate the spread of HIV/AIDS. In Botswana for instance, Odirile (2000) discovered that men who have been ill for lengthy periods may be advised by traditional doctors to sleep with a virgin girl. In tswana culture, long illness is interpreted as the result of a spell or a curse rather than anything having to do with sexual behavior. A long illness of a male may be attributed to his breaking of a taboo such as sleeping with a woman in her menstrual period; having intercourse with a widow or with a woman who has had a miscarriage. Similarly, some beliefs

can result in increased risk of HIV infection. One especially dangerous myth that is found in some cultures around the world is that young women and girls are often the target of older men in search of “safe” sexual partners, including men who believe the myth that sex with a virgin will cure their HIV infection (Matlin and Spence, 2001). While this is untrue, increasing numbers of young girls are infected because of this practice.

In an African society, the dictates is that women are never equal to men. Going by the cultural norms, a woman is to be seen as a half human being or ‘junior male’ or even property that could be inherited. Buckley (1997) observed that the practice of a wife inheritance is one reason Kenya’s Busia district is reeling from AIDS. The infection rate in its towns runs about 30 percent, while the rate in the villages is between 14 to 16 percent. Most possess little education, have no property and in fact, do not hold jobs and therefore lack the requisite skills to find one easily. They must choose to be inherited and be infected and have food or starve. Recently, on 18th November 2003; a group of 29 Kenyan women all of the HIV positive have formed a club to fight the culture of wife inheritance, which they blame for the spread of HIV/AIDS.

Similarly, Egbemode (1999) in Laah (2003) investigated the Kalangas of Zimbabwe where sex between a father in-law and

daughter in-law is not only permissible but also compulsory. It is an initiation act never to be ignored and is meant to welcome the new bride into the household. Consequently, these practices have made the African widow a veritable specimen of suffering and invariably aided the spread of AIDS. In the same vein, in some areas in Igbo land, Nigeria, a widow is supposed to mourn her late husband for one year after which she is taken to the river for the 'Aja-ani' ritual during which the 'Aja-ani' priest 'rapes' her. In some other African societies, the widow is raped by many as ten men; to cleans her up and make her available for her next husband to be.

Moreover, the African society is polygamous in nature. Fasugba (1999) in Laah (2003) has argued that if a prostitute spreads AIDS fast in a society because she shares her sex partners with other women at the same time, then a polygamous wife who is compelled to share her sex partner with other wives is at the same time equally exposed to the spread of HIV/AIDS. Both the polygamist and a patron of prostitutes have one thing in common that is, both men have more than one sex partners at the same time. In fact, the spread of AIDS is further explained by what many intellectuals refer to as serialized polygamy; the practice in which a man has several wives and keeps them in different homes.

In many societies in the world, men and women often find it difficult to talk about sex and to reveal one's HIV status. In a study of Uganda for example, Magezi (1991) discovered that one of the reasons why the control of the AIDS epidemic was initially hampered was the reluctance by the people to discuss sexual matters. Community leaders were disinterested in advocating the use of condom because the general view was that anybody using condom was probably thought to be promiscuous. Yet, advocating abstinence, faithfulness or condom use can be difficult for many couples. Furthermore, in the community, openly discussing sexually transmitted infections can often mean breaking local taboos, resulting in a loss of prestige. And many men are afraid of revealing a HIV-positive diagnosis because they fear losing their jobs and being rejected by their social group, or because they feel guilty towards their regular partner. This is indeed a general belief in most African societies.

2.6 Gender and Vulnerability to HIV/AIDS

There are daunting problems faced by women. It is estimated that in parts of Africa, although 60 to 80 percent of women infected with HIV have only one sexual partner, their partners are unwilling to wear condoms and neither do they remain

faithful. The predicament of most women in Africa is the unwillingness of their spouse to use condom during sex. World Health Organization (WHO, 1997) in Laah (2003) observed that while violence in its many forms can increase risk of HIV transmission for both males and females, young women are particularly susceptible to abuse. The percentage of sex crime victims of 15 years old or younger is 58 percent in Malaysia, 62 percent in the U.S.A, 58 percent in Chile and 40 percent in Papua New Guinea. In Botswana, more than two-fifth of all the rape cases that gets to the courts involve girls who are under 16 years of age. The incidence of rape is now been linked with high prevalence of HIV/AIDS in South Africa.

By the end of 2005, women accounted for nearly half of all people living with AIDS worldwide, and represent almost 60% of infections in sub-saharan Africa. The impact on women is also growing in Eastern Europe, Central Asia and South-Eastern Asia. Moreover, young women are several times more likely than young men to contact the disease through heterosexual. Worldwide 62% of infected young people are girls, and that number soars to 77% in sub-saharan Africa (UNAIDS/WHO, 2005).

One other reason for women vulnerability to contracting HIV is biological when compared to men. The large mucosal structure

of the vaginal and the high concentration of the virus in semen put women at risk of acquiring HIV during unprotected sexual intercourse (NIAID, 2001). A woman's vulnerability to the virus is attributable not only to biological differences, but also to deeply entrenched socio-economic inequalities that further compound her risk. In addition, women often have difficulty negotiating safer sex with their partners because of their lower social status, economic dependence on men and fear of violence. Unequal social roles and vulnerability to men's demands also mean that women are more likely to become infected with HIV at an earlier age than young men are. In the study of Walsh (2001) he said the most affected countries, infections rates in girls are five to six times higher than infection rates in adolescent boys. This is because 70% of the poor people in the world are women. Hence, they have fewer economic options. They are far more vulnerable because of absolute poverty to engage in transactional sex to pay for food, school fees and other necessities. They are also vulnerable to coercive or forced them into sex and often unable to negotiate for condom use. One in three women is even more likely to be abused.

Besides, many women, particularly married women, cannot control the circumstances under which sex takes place. They are especially unable to negotiate the use of condom with their

husbands who may have extramarital partners. Some research indicates that married women are in fact more at risk for HIV than unmarried women are, because they are frequently exposed to intercourse within marriage. When HIV infection occurs within a couple or a family, women often assume a disproportionately large role in caring for those living with the virus.

Indeed, once they have contacted HIV, many women lack access to health care and social support, due in part to their disadvantaged socioeconomic status. On the other hand, culture and language barriers also impede women's access to prevention information and other services. Regardless of which partner first became infected, their partners and society often blame women when HIV surfaces in a family, especially when a child is infected with the virus at birth. As a result, fear of isolation, rejection and social stigma, in addition to the threat of partner violence, often discourages women from revealing their HIV status to their partners, or even from being tested for the virus. The same violence and the resulting inability to discuss safer sex or partner infidelity cause many women to believe that they cannot protect themselves from possible HIV transmission.

Besides, as AIDS ravages families and communities, the burden of caring for ill family members rests mainly with women

and girls, many of whom may be seriously ill themselves. A woman affected by HIV/AIDS is plunged further into poverty, losing the ability to provide for herself and her children. Combined with pervasive social stigma and the collapse of traditional family and support structures, HIV/AIDS are eroding the status of women in many countries.

In fact, in many societies there is a culture of silence that surrounds sex which dictates that ‘good’ women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or even when informed, makes it difficult for them to be proactive in negotiating safer sex.

The traditional norm of virginity for unmarried girls that exist in many societies, paradoxically, increases young women’s risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can clean a man of infection and because of the erotic imagery that surrounds the innocence and passivity associated with virginity. In addition, in cultures where virginity is highly valued, research has shown that some young women practice

alternative sexual behaviors, such as anal sex, in order to preserve their virginity, although these behaviors may place them at increased risk of HIV.

Because of the strong norms of virginity and the culture of silence that surrounds sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescent and adult women.

In addition, women's economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely, that they will leave a relationship that they perceived to be risky. In many cultures, virginity is considered to be a feminine ideal, using barrier methods or non-penetrative sex as a safer sex options, also present a significant dilemma for women.

Finally, male violence against women is another factor that contributes both directly and indirectly to women's vulnerability to HIV. In population base-studies conducted worldwide, 10 to over 50 percent of women report physical assault by an intimate partner. Moreover, one-third to one-half of physical abused women report sexual coercion.

To further buttress the above assertion, a review of literature on the relationship between violence, risky behavior, and productive health, conducted by Heise and colleagues (1999) shows that individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners and trade sex for money or drugs. This relationship is also apparent in the findings from a study conducted in India. In this study men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. And men who reported STD symptoms were 2.4 times more likely to abuse their wives than those who did not. From other research we also know that physical violence, the threat of violence and the fear of abandonment act as significant barriers for women to negotiate the use of condom, discuss fidelity with their partners, or leave relationships that they perceived to be risky.

In addition, data from a study conducted in Tanzania by Mbwambo (2000) suggest that for some women the experience of violence could be a strong predictor of HIV. In that study, women who sought services at a voluntary HIV counseling and testing center in Dar-es-salaam, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were negative.

The unequal power balance in gender relations increases men's vulnerability to HIV infection, despite, or rather because of their greater power. United Nation for AIDS, (1999) reveal the prevailing norms of masculinity that expect men to be more knowledgeable and experienced about sex, put men, particularly young men at risk of infection because such norms prevent them from seeking information on admitting their lack of knowledge about sex or protection and coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood.

In many societies worldwide, it is believed that variety in sexual partners is essential to men's nature as men, and that men will seek multiple partners for sexual release. It is a hydraulic model of male sexuality that seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or a reduction in the number of sexual partners.

Moreover, notions of masculinity that emphasize sexual domination over women as a defining characteristic of manhood contribute to homophobia and the stigmatization of men who have sex with men. The stigma and fear that result force men who have sex with men to keep their sexual behavior secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male.

Besides, men in many societies are socialized to be self-reliant, not to show their emotions and not to seek assistance in times of need or stress (WHO, 1999). This expectation of vulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk. Overall, these manifestations of traditional notions of masculinity are strongly associated with a wide range of risk-taking behavior. For example, in a national survey carried out in United State by Courtenay (1998) on adolescent males' age15 to 19 found that young men who adhered to traditional views of manhood were more likely to report substance use, violence, delinquency, and unsafe sexual practices.

2.7 Decision Making and HIV/AIDS

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services treatments. For example, the Tanzania study conducted by Mbwambo (1999) found that there were gender differences in the decision-making that led to the use of HIV voluntary counseling and testing services. While men made the decision to seek

Voluntary Counseling and Testing (VCT) independent of others, women felt compelled to discuss testing with their partners before accessing the service, there creating a potential barrier to accessing VCT services.

Women social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden; they are infected and they are women. In many societies being socially ostracized, marginalized, and even killed are potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child.

In a recent study conducted by researchers in Botswana and Zambia in collaboration with researchers from ICRW, men and women expressed concern for women who test positive because they felt that men would be likely to abandon a HIV positive partner. On the other hand, it was expected that women would initially get angry with HIV positive partner, but ultimately accept him (Nyblade and Field, 2000).

2.8 Factors Leading to HIV/AIDS

Several factors put people, particularly susceptible to the risk of HIV/AIDS. One of these factors is poverty. According to United Nations Report, (2001) in Laah, (2003) more than 70% of the nearly 1.3 billion people of the world who live in dire poverty are women and the situation is getting worse by the day. It is largely for economic reasons that most women engage in prostitution and majority of these woman are unable to negotiate for sex.

Opolot, (1998) observed the main factor as economic and culture. He said many young women opt for rich elderly men to meet their economic needs. They are not self reliant so they cannot say no to sex when it is the only way they can raise an income, hence no negotiation for safer sex. Similarly, Meyer (2001), identified some of the factors of the disease, which includes unprotected sex, literacy and language difficulties (hampering communication), the economic and cultural status of women, for example, placing them in a poor negotiating position with regard to protected sex. Cultural beliefs and practices such as wife inheritance; and migrant labor, where men are away from home for a long periods of time, resulting in reliance on prostitution as a sexual outlet.

Apart from poverty, United State president's emergency plan for AIDS relief in collaboration with Federal Ministry of Health (FMOH, 2004) indicate many risk factors that contribute to the HIV epidemic in Nigeria, including mobility of Commercial Sex Workers (CSW), polygamy, high risk practices among itinerant workers, high prevalence of sexually transmitted infections (STI), clandestine high risk of homosexual practices, international trafficking of women, and irregular blood screening.

Unfortunately, the public sector in Nigeria is largely unregulated and, more importantly, has no formal connection to the public health system where HIV interventions are delivered. More so, training and human resource development is severely limited in all sectors and will hamper program implementation at all levels. Above all, care and support is limited because existing staff are overstretched and most of them have insufficient training in key technical areas to provide complete HIV services; these could also be risk factors to be acknowledged.

Furthermore, peacekeepers in the mission area are vulnerable to contracting sexually transmitted infections (STI) including HIV. For example, Liberia has been cut off from HIV information for more than a decade due to the prolonged civil war,

the knowledge level of the pandemic remains low. Other factors putting people at risk of acquisition and transmission of HIV are:

1. Separation from their community, families and regular sexual partners may lead them to seek short-term or casual sexual partners.
2. High-risk behavior associated with multiple partners with unprotected sexual relationships.
3. Peer pressure.
4. Stress.
5. Lack of information and education about the pandemic.
6. Antagonistic relationships between social norms and values, and the realistic behavioral patterns in the community.
7. Incidences of sexually transmitted infections.
8. Improperly screened blood for transmission.
9. Un-sterilized needle, especially the one used by drug addicts.
10. Infected mother to child. (UNAIDS/WHO, 2005), revealed that HIV-positive women may transmit HIV to their children during pregnancy, in childbirth or through breast-feeding. Today, mother-to-child transmission (MTCT) of HIV is the primary mode of acquisition of HIV for the more than 2 million children living with HIV. While antiretroviral therapy

significantly reduces the risk of MTCT of HIV, prevention coverage in the 30 African countries with the highest HIV prevalence is only 5 percent.

2.9 Review Studies on HIV/AIDS

The attitude and behaviors of people both in the developed and developing nations must have contributed to the spread of HIV/AIDS in the world. Unuigbe and Ogbeid (1999) stated that the attitude of students' toward HIV/AIDS is still to a large extent negative, most especially the University undergraduate students. Similarly, research conducted in three universities of Ile-Ife, Lagos and Ado-Ekiti shows a negative attitude toward HIV/AIDS. In another study, Omoteso (2003) stated that the university students' perception of HIV/AIDS was adequate but most of them displayed a high degree of aversion to students living with HIV/AIDS.

A study carried out in University of Nsukka by Walaka (2002) shows that those males and females who are not married are more likely susceptible to HIV/AIDS than the married ones.

Haoses (2000) in a study conducted in University of Namibia stated that the indiscriminate sexual relationships among students in the university campus after their first registration are responsible for the spread of HIV/AIDS in the university. The attitude and

behaviors of students about sexual relation changes as their academic year increase in the universities.

Another related study conducted in Botswana by Stella (1999) who investigated about the attitude, knowledge and behaviors of campus students. She found out that the indiscriminate sexual relation among female in the campuses has resulted into spread and prevalence of HIV/AIDS. She concluded that the university environment has greater risk contracting HIV/AIDS, reasoning that abuse of freedom, increase sexual temptation, peer pressure and casual sex are the influencing factors of HIV/AIDS prevalence. In the same vain (UNAIDS, 2000) observed that Botswana is one of the countries in southern Africa severely impacted on by HIV/AIDS. Given the pervasive nature of the illness, the university community is likely to experience similar impact as it is in the national community. Research implemented by the world AIDS body among the students' has identified a number of risk behaviors for HIV/AIDS, including multiple sexual partners, unprotected sex and sex for money and favors. These behaviors if left unchanged can seriously compromise the university community.

Most writer and researchers on HIV/AIDS are concerned with the awareness, spread without much concern for knowledge,

attitudes, and belief toward HIV/AIDS, and the consequences of this epidemic. However, this research intends to examine these social variables.

2.10 Summary

The review studies, so far are concerned with the youths in the university and the public in general, to identify the factors associated with risky sexual activity. It focuses on young people because they engage in more frequent sex and have long period of sexual activities before them; thus, future preface of AIDS depend heavily on the direction that prevention programme takes with respect to young people.

Indeed, handfuls of studies have already added to our knowledge of attitudes about sexuality and disease, of impact on families and individuals and of caring institutions. Also many of the studies have demonstrated the life pattern of young sexual risk in exploring questions relating to the disease.

Whichever view is embraced, a few basic observations are important. AIDS is a part of development process – a part of the fabric of each society – and every society will present slightly different issues to analyse. The complexity of the problem and complexity of sexual behavior militates against it easy, profiles for

behavior intervention especially among young people, significant negative attitudes toward the disease, towards those affected and fear of the stigmatized group have been observed. In addition, there are certain beliefs in the form of cultural taboos and practices that help to aggravate the spread of HIV/AIDS e.g. in Tswana culture in Botswana, long illness is interpreted as the result of a spell or a curse rather than anything having to do with sexual behavior. In the studies, it was also observed that students work against their knowledge.

CHAPTER THREE

METHODOLOGY

3.1 Introduction:

This chapter describes and discusses the method involved in the study, the research design, population of the study, sample and sampling procedures used. The chapter also discusses the instrument, validity of the questionnaire, reliability, pilot study, data collection as well as data analysis and the statistical tools involved.

3.2 Research Design

To carry out this study, the survey research design was adopted. It was adopted due to its ability to study small and large population group or groups of people. Its ability to determine the status of a given phenomenon also accounts for its applicability to this study. The obvious thing about survey is that it focuses on people, their belief, opinions, attitudes, motivations, and behaviour. It is embracive and practical in nature.

This method involves gathering data about the target population from a sample and generalizing the findings obtained from an analysis of the entire population. Afolabi, 1993 cited in

Shabu, (1997), supports this approach because survey researches study large and small population, which enables the researcher to discover relative incidence and distribution on the characteristics of the population. Also, Nwanga, 1991 cited in Mohammed (2001) said a survey research method is the one in which a group of people or items are studied by collecting and analyzing data from only few people or items considered to be representatives of the entire population. Therefore, with the application of survey method to this study, the knowledge, attitude and belief of students toward HIV/AIDS that involve seeking personals opinion can be thoroughly investigated.

3.3 Population of the Study

The target population for this research consists of the undergraduate students' in the selected tertiary institutions in Zaria educational Zone of Kaduna state.

The rationale behind restricting the population to undergraduate students' is because they are more susceptible to the pandemic. This is the stage in which many undergraduate youths want to expose themselves sexually without adequate knowledge of the effects of having contacting HIV/AIDS. The new students' were considered adequate as well as final year students'

of the institutions under study because they are more exposed to the school environment and they perceived the environment different from the new students'.

The number of institutions is three with a total population of forty seven thousand (47,000) but it will not be possible to include all the population here in the study. The selected institutions and the population of students' were obtained in the records of these institutions in (2006) as follows:

Table 3.1: Showing the selected institutions in Zaria Educational Zone of Kaduna State.

S/N	INSTITUTIONS	POPULATION OF STUDENTS
1	Ahmadu Bello University	21,000
2.	Federal College of Education	16,000
3.	Nuhu Bamali Polytechnic	10,000
	Total	**47,000**

Sources: 1. Management and information services; Ahmadu Bello University Zaria.

2. Student Enrolment Office; Federal College of Education Zaria.

3. Statistics Office; Nuhu Bamali Polytechnic Zaria.

3.4 Samples and Sampling Procedure

To determine the sample size, simple randomization sampling technique was used to get the sample for this study. Roscoe (1969) recommendation for sampling procedure of five hundred (500) was adopted. Therefore, out of a population of forty-seven (47,000) in the selected institutions in Zaria educational zone five hundred (500) was taken. Random sampling method was used in selecting the respondents from the selected institutions. The sample size was distributed among the institutions involved in the study. A ratio scale method was used in allocating the sample size to each institution. This is necessary, since it gives every member in the population an equal opportunity of being selected.

Table 3.2 Showing Samples of Respondents.

S/No	Institutions	Population	Samples
1.	Ahmadu Bello University	21,000	200
2..	Federal College of Education	16,000	150
3.	Nuhu Bamali polytechnic	10, 000	150
	Total	**47,000**	**500**

Out of a population of 47,000 in the selected institutions, 500 was taken, this is in line with Roscoe, 1969 cited in Mamman, (2004) who suggested that 500 respondents as the sample size, no matter how large is the population.

3.5 Instrumentation

The instrument used in this study is questionnaire for students. The questionnaire intends to seek information on the basic characteristics that is reflected on the variables being tested. The questionnaire, titled Knowledge, Attitude and Belief Questionnaire (KABQ) was adopted from Shabu, 1997 and modified by the researcher. Each section contains proportional items that answer the questions raised. The questions are rated on a five point Licker scale of:

1 SD = Strongly Disagree

2 DA = Disagree

3 NS = Not sure

4 A = Agree

5 SA = Strongly Agree

The items in the questionnaire were generated through a review of previous studies. In scoring the items related to each of the five point Licker scale, respondent's will have a possible total

score ranging from 1 to 5 which represent a respondent's opinion. The higher the score the more influenced the respondent is by the scale.

The structured questionnaires were divided into five sections of:

Section A. Personal data

Section B. Knowledge of HIV/AIDS

Section C. Attitude towards HIV/AIDS

Section D. Socio-economy status

Section E. Belief about HIV/AIDS

The questionnaire method makes it more effective to administer and score. It also has the advantage of collecting objective and reliable information from respondent. According to Schofield, (1978) questionnaire is a mass written interview. It contains questions that might be asked in face-to-face interview and as such, it represents the group test.

3.5.1 Validity

The confirmation of validity is necessary to ensure that an instrument measures truly and accurately what it sets out to measure; therefore, the instrument was shown and subjected to proper scrutiny by lecturers in the Faculty of Education, Ahmadu

Bello University, Zaria. This is in order to establish its content validity. Kerlinger, (1973) observed that validation by others is an effective method for content validation of research instrument.

3.5.2 The Pilot Study

The result of the pilot study was used to ascertain the reliability of the instrument. Winner, (1987) in Mohammed, (2001) confirmed that a pilot study before the main study would help to check the problem areas, ambiguity and possible confusion that may be associated with the instrument. The pilot study was conducted in Ahmadu Bello University Zaria. A total of 80 questionnaires were distributed, and 70 were returned. This is in agreement with Nwougo (1991) who said that pilot testing is usually done on a much smaller scale than the main study, but under similar conditions. The test was conducted for a period of two weeks.

3.5.3 Reliability

The result of the pilot study was used to ascertain the reliability of the study. To obtain reliability for factual questions, Cheek (1966) notes that, "internal checks in the forms of logical tests in the questionnaire should be included". In line with this, a

number of questions were built into the KABQ to give a clue to the consistency of responses. For the reliability coefficient, the split half method was used to determine the reliability of the research instruments. The researcher split the students score into even and odd numbers and calculated the reliability coefficient that came out to be 0.61. This gave the researcher some level of confidence in the relevance and reliability of the instrument.

3.6 Procedure for Data Collection

The Knowledge, Attitude and Belief Questionnaire (K.A.B.Q) for HIV/AIDS were aim to gather information from students', considering the problems of the epidemics. In preparing the instrument, the researcher designed and framed the items in simple terms in order to make it easy for the respondents to interpret and fill appropriately. A letter was prepared and addressed to the authorities of the institutions involved in the study, seeking their permission to allow the researcher carry out the study in their institutions.

Another letter was prepared and attached to the instrument that was address to the respondents; this was mean to introduce the researcher to the respondents and to state the purpose and significance of the study to the respondents.

In order to acquire more appropriate respond, the students' were made to understand that the questionnaire was purposely designed for research and they were required to give honest responses.

3.7 Data Analysis

The data gathered from this study was analyzed using One-way ANOVA, t-test and Pearson Product Moment Correlation Coefficient (PPMC). ANOVA was used for hypothesis 1and 6; t-test was used for hypotheses 2, 4 and 5 while correlation was used for hypothesis 3 to test the five null- hypotheses. This enable the researcher determine whether there exist some significant difference, relation or not and to either retain or reject each null-hypothesis. Five percent level of significance was set (Alpha 0.05). The computer statistical package for Social Sciences (SPSS) was used in analyzing the data.

CHAPTER FOUR

RESULT AND DISCUSSION

4.1 Introduction:

This chapter deals with the result of data collected. The result are presented according to the research questions and hypotheses stated in chapter one. The focus of the study was to assess the Knowledge, Attitude and Belief of undergraduate youths toward HIV/AIDS.

The data obtained from the questionnaire were used to answer a number of research questions and hypotheses postulated. In order to ascertain the statistical evidence of the data analysis, one-way ANOVA, correlation and t-test method were used to test the hypotheses that guided the study. The computer package for analyzing data in the social science and education (SPSS) was used in analyzing the data. Significant level of 0.05 was adopted as the basis for rejecting or accepting hypotheses.

The findings of this research were obtained by using suitable and appropriate statistical techniques. Therefore, in order to satisfactorily answer the research questions and hypotheses various techniques were used. These includes percentages,

means, standard deviation, and t-test. Percentages were mainly used to find out the disparity in the responses of students on knowledge, attitude and belief toward HIV/AIDS. Mean and standard deviation were used to find variation among the six factors studied. In addition, t-test was used to analyze the pairs of differences among gender (male and female), married and unmarried, student's resident in the campus and those residents outside the campus. Correlation was also used to analyze the relationship of students' socio-economic background with their knowledge, attitude and belief toward HIV/AIDS. Again, one way ANOVA was used for the differences of various academic levels of students' knowledge, attitude and belief toward HIV/AIDS.

The questionnaire was divided into five sections. Section one was on the biodata of the respondents, Section two covers the scale value of knowledge toward HIV/AIDS; and contains ten items. Section three also contains the scale value of attitude toward HIV/AIDS and it has twelve items. While section four deals on socio-economic status, section five was the scale value of belief toward HIV/AIDS. Section four and five contains eight and nine items respectively. There are thirty-nine items in all in the scale. The percentages for all the factors are presented below:

Table 4.1 Percentage of the respondents

Variables		Frequency	Percentages
Sex	**Male**	**271**	**44.2**
	Female	**229**	**45.8**
	Total	**500**	**100.0**
Level	**400L**	**188**	**37.6**
	HND II	**75**	**15.0**
	100L	**89**	**17.8**
	NCE I	**72**	**14.4**
	OND I	**76**	**15.2**
	Total	**500**	**100.0**
Marital Status	**Married**	**42**	**8.4**
	Single	**452**	**90.4**
	Divorce	**4**	**.8**
	Others	**2**	**.4**
	Total	**500**	**100.0**
Residence	**On Campus**	**216**	**43.2**
	Off Campus	**284**	**56.8**
	Total	**500**	**100.0**

Table 4.1 above shows the distribution of respondents by sex, age, present level, marital status and place of residence. The distributions of male respondents were 271; representing 54.2% while female respondents were 229; representing 45.8%.

Also, the distribution of respondents according to their academic levels shows that those in 400L were 188, representing 37.6%, HND II were 75, representing 15.0%, 100L were 89,

representing 17.8%, NCE I were 72 representing 14.4%, and OND I were 76, representing 15.2%.

Again, the distribution of respondents according to their marital status shows that 42 respondents are married, representing 8.4%, while 452 respondents representing 90.4% are single. The number of respondents who are divorced are 4, representing 0.8%.

As for the distribution of respondents according to their residence, the data show that those respondents who are on campus were 216, representing 43.2% and those respondents who are living off campus were 284, representing 56.8%.

4.2 Hypotheses Testing

This research studied students' knowledge, attitude and belief toward HIV/AIDS. Hypotheses were tested at 0.05 level of significance to investigate some pairs of difference among some of these students' knowledge, attitude and belief toward HIV/AIDS.

HYPOTHESIS 1.

There is no significant differences among students of various levels of academics (400L, 100L, HND II, OND I and NCE I) on their knowledge, attitude and belief toward HIV/AIDS.

Table 4.2: Oneway ANOVA on the differences of various academic levels of students knowledge, attitude and belief toward HIV/AIDS.

Variables	Levels	N	$\bar{x}$	SD	df	F	Sig.
Knowledge	**400L**	**188**	**39.19**	**4.51**	**499**	**3.37**	**.010**
	HND II	**75**	**38.56**	**4.16**			
	100L	**89**	**39.37**	**4.86**			
	NCE I	**72**	**37.45**	**4.04**			
	OND I	**76**	**37.69**	**4.79**			
	Total	**500**	**38.65**	**4.55**			
Attitude	**400L**	**188**	**36.51**	**5.73**	**499**	**7.64**	**.000**
	HND II	**75**	**36.64**	**5.58**			
	100L	**89**	**36.17**	**4.54**			
	NCE I	**72**	**40.34**	**5.89**			
	OND I	**76**	**38.43**	**7.21**			
	Total	**500**	**37.31**	**5.95**			
Belief	**400L**	**188**	**32.75**	**4.72**	**499**	**3.43**	**.009**
	HND II	**75**	**32.13**	**4.57**			
	100L	**89**	**33.33**	**4.35**			
	NCE I	**72**	**32.69**	**4.94**			
	OND I	**76**	**30.81**	**4.78**			
	Total	**500**	**32.46**	**4.72**			

(P < 0.05) Significant

Table 4.2 above shows significant difference on knowledge, attitude and belief of students' levels of academic pursuit toward HIV/AIDS, therefore the hypothesis is rejected.

Table 4.2.1: Mean separation test on the knowledge, attitude and belief of the respondents on HIV/AIDS.

Dependent Variable	(I) Level	(J) Level	Mean SD. (I-J)	Std. Error	Sig.
Knowledge	400L	HND II	.63681	.61603	.899
		100L	-.17398	.58036	.999
		NCE I	1.73848	.62513	.104
		OND I	1.49944	.61312	.202
	HND II	400L	-.63681	.61603	.899
		100L	-.81079	.70701	.859
		NCE I	1.10167	.74421	.701
		OND I	.86263	.73415	.847
	100L	400L	.17398	.58036	.999
		HND II	.81079	.70701	.859
		NCE I	1.91245	.71496	.130
		OND I	1.67342	.70448	.229
	NCE I	400L	-1.73848	.62513	.104
		HND II	-1.10167	.74421	.701
		100L	-1.91245	.71496	.130
		OND I	-.23904	.74180	.999
	OND I	400L	-1.49944	.61312	.202
		HND II	-.86263	.73415	.847
		100L	-1.67342	.70448	.229
		NCE I	.23904	.74180	.999
Attitude	400L	HND II	-.12936	.79200	1.000
		100L	.33086	.74614	.995
		NCE I	-3.83658*	.80371	.000
		OND I	-1.92357	.78827	204
	HND II	400L	.12936	.79200	1.000
		100L	.46022	.90898	.992
		NCE I	-3.70722*	.95680	.005
		OND I	-1.79421	.94386	.462
	100L	400L	-.33086	.74614	.995
		HND II	-.46022	.90898	.992
		NCE I	-4.16745*	.91920	.000
		OND I	-2.25444	.90573	.187
	NCE I	400L	3.83658*	.80371	.000
		HND II	3.70722*	.95680	.005
		100L	4.16745*	.91920	.000
		OND I	1.91301	.95371	.187
	OND I	400L	1.92357	.78827	.204
		HND II	1.79421	.94386	.462
		100L	2.25444	.90573	.187
		NCE I	-1.91301	.95371	.404

Belief	**400L**	**HND II**	**.61667**	**.63960**	**.920**
		100L	**-.58708**	**.60257**	**.917**
		NCE I	**.05556**	**.64906**	**1.000**
		OND I	**1.93421**	**.63659**	**.057**
	HND II	**400L**	**-.61667**	**.63960**	**.920**
		100L	**-1.20375**	**.73407**	**.611**
		NCE I	**-.56111**	**.77269**	**.971**
		OND I	**1.31754**	**.76224**	**.560**
	100L	**400L**	**.58708**	**.60257**	**.917**
		HND II	**1.20375**	**.73407**	**.611**
		NCE I	**.64263**	**.74232**	**.945**
		OND I	**2.52129***	**.73145**	**.019**
	NCE I	**400L**	**-.05556**	**.64906**	**1.000**
		HND II	**.56111**	**.77269**	**.971**
		100L	**-.64263**	**.74232**	**.945**
		OND I	**1.87865**	**.77019**	**.205**
	OND I	**400L**	**-1.93421**	**.63659**	**.057**
		HND II	**-1.31754**	**.76224**	**.560**
		100L	**-2.52129***	**.73145**	**.019**
		NCE I	**-1.87865**	**.77019**	**.205**

The mean difference is significant at the 0.05 level.

Tables 4.2.1 above show the mean separation test using the Scheffe procedure. The stars indicate groups that are significantly different from each other.

HYPOTHESIS 2

There is no significant difference between married and unmarried students on the level of knowledge, attitude and belief toward HIV/AIDS.

Table 4.3: t-test analysis on the differences between married and unmarried students on the level of knowledge, attitude and belief toward HIV/AIDS

Variables	Marital Status	N	$\bar{x}$	SD	df	t-cal	Sig.	t-critical
Knowledge	Married	42	39.40	3.98	492	1.10	.272	1.96
	Single	452	38.60	4.55				
Attitude	Married	42	37.71	5.81	492	0.43	.661	1.96
	Single	452	37.29	5.87				
Belief	Married	42	32.92	4.40	492	0.57	.553	1.96
	Single	452	32.50	4.63				

(P > 0.05) Not significant

Table 4.3.2 above shows that there is no significant difference in the mean scores of married and unmarried students' on their knowledge, attitude and belief towards HIV/AIDS, hence, the hypothesis is accepted. The underlying reason here is that all the calculated values are less than their critical value.

HYPOTHESIS 3.

There is no significant relationship between students' socio-economic status and their knowledge, attitude and belief toward HIV/AIDS.

Table 4.4: Intercorrelation matrix between knowledge of HIV, attitude, belief as well as socio-economic status of students.

Intercorrelation matrix	**Knowledge**	**Attitude**	**Belief**	**S.E.S**
Knowledge	**000**			
Attitude		**000**		
Belief			**000**	
S.E.S	**.188r**	**.307r**	**.266r**	**000**

Correlation is significant at the 0.01 level (2 tailed)

There is significant relationship between socio-economic status of students' and their knowledge, attitude and belief toward HIV/AIDS. The results show a very high significant relationship in all cases. The high level of relationship shows obvious and inevitable impact of these social elements toward HIV/AIDS. Therefore, the hypothesis is rejected.

HYPOTHESIS 4.

There is no significant difference between male and female students on the level of knowledge, attitude and belief toward HIV/AIDS.

Table 4.5: t-test analysis on the significant difference between male and female students level of knowledge, attitude and belief towards HIV/AIDS.

Variables	Sex	N	$\bar{x}$	SD	t-cal	t-critical
Knowledge	**Male**	**271**	**38.72**	**4.38**	**.389**	**1.96**
	Female	**229**	**38.56**	**4.75**		
Attitude	**Male**	**271**	**37.91**	**5.87**	**2.47**	**1.96**
	Female	**229**	**36.60**	**5.97**		
Belief	**Male**	**271**	**32.11**	**4.41**	**-1.76**	**1.96**
	Female	**229**	**32.86**	**5.05**		

(P > 0.05) Not Significant

Table 4.5 indicates that there is no significant difference between male and female respondents in their knowledge and belief toward HIV/AIDS; therefore, the hypothesis is accepted. This is because their t-calculated is less than t-critical. Concerning attitude, the hypothesis is significant; therefore, the hypothesis is rejected; the reason being that t-calculated is greater than t-critical.

HYPOTHESIS 5

There is no significant difference between residential and non-residential students knowledge, attitude and belief toward HIV/AIDS.

Table 4.6: t-test analysis on the significant difference between residential and non-residential students' knowledge, attitude and belief toward HIV/AIDS.

Variables	Residence	N	$\bar{x}$	SD	df	t	Sig.	t-critical
Knowledge	**On camp.**	**216**	**38.98**	**4.34**	**498**	**1.40**	**.161**	**1.96**
	Off camp.	**284**	**38.40**	**4.69**				
Attitude	**On camp.**	**216**	**37.08**	**5.88**	**498**	**-.74**	**.455**	**1.96**
	Off camp.	**284**	**37.48**	**6.00**				
Belief	**On camp.**	**216**	**33.03**	**4.66**	**498**	**2.37**	**.018**	**1.96**
	Off camp.	**284**	**32.02**	**4.73**				

(P > 0.05) Not Significant

Table 4.6 reveals that there is no significant difference between residential and non-residential students' knowledge and attitude towards HIV/AIDS; hence, the hypothesis is therefore accepted. Concerning belief, there is a significant difference between them toward HIV/AIDS therefore the hypothesis is rejected.

HYPOTHESIS 6

Students from different institutions from where the research subjects were drawn do not differ significantly in their knowledge, attitude and belief towards HIV/AIDS.

Table 4.7: One-way Descriptive analysis of variance on students' from different institutions on their knowledge, attitude and belief towards HIV/AIDS.

Variables	School	N	$\bar{x}$	SD	df	f	Sig.
Knowledge	**ABU**	**200**	**39.12**	**4.78**	**498**	**1.90**	**.150**
	FCE	**151**	**38.56**	**4.39**			
	NBP	**148**	**38.17**	**4.30**			
	Total	**499**	**38.67**	**4.53**			
Attitude	**ABU**	**200**	**35.87**	**5.35**	**498**	**13.56**	**.000**
	FCE	**151**	**39.12**	**5.77**			
	NBP	**148**	**37.45**	**6.40**			
	Total	**499**	**37.32**	**5.95**			
Belief	**ABU**	**200**	**33.45**	**4.73**	**498**	**8.28**	**.000**
	FCE	**151**	**32.20**	**4.67**			
	NBP	**148**	**31.44**	**4.50**			
	Total	**499**	**32.47**	**4.71**			

(P < 0.05) Significant

Table 4.7 reveals that there is a significant difference between respondents from the three institutions in their attitude and belief towards HIV/AIDS, hence, the hypothesis is therefore rejected. Concerning knowledge toward HIV/AIDS there is no significant difference between them; therefore, the hypothesis is accepted.

Table 4.7.1: Mean separation test of the respondents from various institutions on the knowledge, attitude and belief toward HIV/AIDS.

Dependent variable	(I) Inst.	(J) Inst.	Mean Difference (I-J)	Std. Error	Sig.
Knowledge	ABU	FCE	.55046	.48825	.530
		NBP	.94432	.49107	.158
	FCE	ABU	-.55046	.48825	.530
		NBP	.39386	.52386	.754
	NBP	ABU	-.94432	.49107	.158
		FCE	-.39386	.52386	.754
Attitude	ABU	FCE	-3.25583*	.62630	.000
		NBP	-1.58270*	.62991	.043
	FCE	ABU	3.25583*	.62630	.000
		NBP	1.67313*	.67197	.046
	NBP	ABU	1.58270*	.62991	.043
		FCE	-1.67313*	.67197	.046
Belief	ABU	FCE	1.24470*	.50098	.047
		NBP	2.00405*	.50386	.000
	FCE	ABU	-1.24470*	.50098	.047
		NBP	.75935	.53751	.369
	NBP	ABU	-2.00405*	.50386	.000
		FCE	-.75935	.53751	.369

The mean difference is significant at the 0.05 level.

Tables 4.7.1 above show the mean separation test using the scheffe procedure. The stars indicate groups that are significantly different from each other.

4.3 Summary of findings

In this study, the following findings were made:

1. The mean scores indicated that the 400L and 100L respondents have reasonable knowledge toward HIV/AIDS when compared to their HND II, OND and NCE I counterparts. Surprisingly, the HND II students are positive in

their attitude toward the disease than the other levels of students. Again, the 400L and OND I respondents, believe more in HIV/AIDS when compared to other levels of students.

2. It was established in the study that the married students are more accurate in their knowledge, attitude and belief toward HIV/AIDS when compared to single students.
3. It was also established in the study that poor socio-economic status of students has a strong impact on their knowledge, attitude and belief towards HIV/AIDS.
4. It was observed in the mean scores that the male students have high level of knowledge and adventurous risk toward HIV/AIDS when compared to female students. Unfortunately, the female students believe more in HIV/AIDS than the male students.
5. The mean scores also revealed that students residing on campus have reasonable knowledge but intolerance attitude than the non-resident students' toward HIV/AIDS. While the non-resident students' belief more in the existence of HIV/AIDS when compared to resident students.
6. Ahmadu Bello University students have higher level of knowledge and belief toward HIV/AIDS when compared to

students from Federal College of Education and Nuhu Bamali Polytechnic. Surprisingly, students' from Federal College of Education and Nuhu Bamali Polytechnic have tolerance attitude toward HIV/AIDS than Ahmadu Bello University students.

4.4 Discussion of the results

The results obtained in the analysis of data contrast with the findings of a number of research works conducted in the past while some aspect agree with the findings of other researchers.

The results obtained are not very much surprising because from all the hypotheses, the research findings show that students level of knowledge toward HIV/AIDS seems to be moderately high especially where it touches or concerns the danger in contacting the disease. This did not however prevent them from engaging in indiscriminate sexual intercourse. It appears, however, that this could be, because of the erroneous belief and intolerant attitude they have toward the disease.

This habit of indiscriminate sexual intercourse by the students could lead to contact with HIV/AIDS; the very menace that has devastated the social and economic fabric of the

population. For example, several youths have become orphans because of the virus infection.

The first hypothesis, which states that there is no significant difference among students' of various level of academic pursuit on their knowledge, attitude and belief toward HIV/AIDS, was tested and rejected. The reason was that the result shows significant difference. It should therefore be noted that majority of the undergraduate students have adequate knowledge, attitude and belief in the existence of HIV/AIDS. However, students' do take undue risk when it comes to negotiating for sex. This may be because of the so-called campus freedom that is having a negative effect on their attitude.

The study has proved in the past that undergraduate students have an understanding and developed positive attitude and believe on the existence of HIV/AIDS. This is in contrast with the finding of Anugwom (2004), in his research, where he observed that students saw AIDS as not really in existence. The source holds that the Western nations are using the pandemic to put Africa in check. However, this study agrees with finding of Lucky (2000), in which he explained that students responses clearly indicate that they know what HIV/AIDS is, how it can be transmitted and how it can be avoided but that their attitude to the

disease is worrisome. Students also believe that the indiscriminate rate of sexual intercourse at the university is very high; a situation that contributes to the spread of HIV/AIDS.

The second hypothesis, which states that there is no significant difference between married and unmarried students on the level of knowledge, attitude and belief toward HIV/AIDS, was also accepted because the result has clearly shown that both married and unmarried students have a similar knowledge, attitude and belief toward the existence of the disease. However, from the mean scores it was observed that married students tend to be more accurate in their knowledge as well as attitude and belief when compared to their single counterparts. This further explains that married students may be more mature in their approach to the disease than the single students may.

This is in agreement with the work of Walaka (2002). His findings showed that students that are susceptible to HIV/AIDS are the male and female students who are not married than the married ones. This may explain the reason why the situation is that of fear among married students. Consequently, it may as well draw attention to the fact that the married students have high level of knowledge, attitude and belief when compared to single students. This could also mean the situation is that of fear among the

married students while most single students' are resistant to all preventive measures.

The result of hypothesis three shows a significant relationship between socio-economic status of students and their knowledge, attitude and belief towards HIV/AIDS. By implication, students economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection they perceived to be less risky. This was supported by the finding of Heise (1999) which revealed that students' who have been sexually abused are more likely to engage in unprotected sex, have multiple sex partners and trade sex for money. However, it is likely that improvement in financial status of students will reduce HIV/AIDS in our tertiary institutions.

Based on hypothesis four, the result as shown in the analysis revealed that there is no significant difference between male and female students on the area of knowledge and belief toward HIV/AIDS. With regards to attitude of male and female students toward HIV/AIDS, the result in the analysis shows significant difference. Judging from the situation, students may not have

gotten specific knowledge and their belief may be erroneous, which probably will lead to poor attitude toward the disease.

The result agrees with the findings of Unuigbe and Ogbeid (1999) who stated that the attitude of people toward HIV/AIDS is still to a large extent negative; especially the university undergraduate students. This has further revealed that both male and female students' may have adequate knowledge and belief toward the existence of HIV/AIDS but their attitude toward it is poor. The poor attitudes against precautionary measures portend many dangers for these institutions and their efforts toward reducing and eradicating the epidemic.

The intolerant attitude of students toward HIV/AIDS could also be as a result of cultural background of the respondents. For example, some cultures consider it a normal social attainment and sometimes encourage young men to experiment sexually before marriage. These cultural attitudes towards sex often result to HIV infections to both male and female. Parents and teachers have a role to play to educate the youths on the pandemic and thus help in prevention and control of the disease. The students should also be encouraged to read more literature on HIV/AIDS made available in their institutions.

In the case of hypothesis five, the result states that there is no significant difference between resident and non-resident students' knowledge and attitude towards HIV/AIDS. The hypothesis is accepted. However, there is a significant difference between their beliefs toward HIV/AIDS. The hypothesis is rejected. The mean scores revealed that resident students have reasonable knowledge but intolerance attitude than the non-residence students toward HIV/AIDS. One can confidently say that community influence may be a factor on the intolerant attitude of the non-resident students. In addition, resident students believe more in HIV/AIDS than the non-resident students.

This has clearly shown that both resident and non-resident students' have similar knowledge and attitude, but their disposition toward what they believe about HIV/AIDS varies. It is evident that the place of students' resident, slightly affect their attitude. Significant difference in their belief may be because of differences in their home setting which has a strong effect on their belief. This agrees with the findings of UNAIDS (2001). According to the United Nations, people are influence by their background; some of which may be very negative in the context of HIV.

Finally, the result of hypothesis six states that there is significant difference in students attitude and belief towards

HIV/AIDS from different institutions. The hypothesis is rejected. About knowledge the result shows not significant, therefore the hypothesis is accepted. This shows that students' in tertiary institutions have moderate level of knowledge and it is homogeneous about the transmission of symptomology and prevention of the disease, though, with great deal of misconception regarding HIV/AIDS. However, their attitude and belief toward the disease is questionable.

This further explained the fact that students may have reasonable knowledge about the role of sexual contact, blood transfusion, infected needles and vertical transmission but their attitude and belief may as well be erroneous toward HIV/AIDS. This agrees with the finding of Deshmukh 1999 in (Oyaziwo, 2005), which revealed that students were knowledgeable about transmission and symptomology, but there were misconception about their attitude and belief toward the mode of HIV transmission. Conversely, Chakaraborty, 1996 in (Oyaziwo, 2005), explained in his finding that students knowledge was inadequate.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction:

The researcher in this chapter summarized the previous chapters, the major findings were highlighted, conclusion were drawn and implications of this pandemic (HIV/AIDS) to human existence. In addition, recommendations were made to reflect the practical applications. It is obvious that the study has contributed in finding solution to the spread of HIV/AIDS in this modern society.

5.2 Summary

The research starts with a general introduction as the major heading; it highlighted the unhealthy situation of HIV/AIDS among youths in tertiary institutions. It presents the objectives, research question and hypotheses. Also highlighted is the statement of the problem, which justifies the course of this study. The research was limited to the basic levels of undergraduate students in tertiary institutions.

Again, a review of the related literature in the areas that are considered to have positive implication on the outcome. The framework of the study gave rise to framing of adequate hypotheses for this study. The hypotheses addressed relevant

issues for reaching the desired effects on the targeted population and the entire society.

Furthermore, the methodology adopted for the study borders on research design used which focused on survey method, population of the study and sampling procedure. Pilot study was conducted and processes of data collection and analysis stressed.

Tables were designed to display the data contents and outcomes, reporting the basic elements that form the opinion of the researcher on the result of the analyzed data's. The findings of this study have agreed with the findings of many researchers in Nigeria and other parts of the world. Finally, some recommendations were made.

5.3 Conclusion:

The study focused on the knowledge, attitude and belief of undergraduate students toward HIV/AIDS. The research was conducted in three tertiary institutions in Zaria Education zone of Kaduna state. The data collected were subjected to intensive statistical analysis to test the six hypotheses raised for the study. Hypothetical analysis was to answer the research questions poised for the purpose of this study. The research hypotheses focused on important areas that have relevance to the success of

the study. Areas of focus such as students' knowledge, attitude and belief toward HIV/AIDS were x-rayed. The effects of socio-economic on students' knowledge, attitude and belief about HIV/AIDS were examined and relevant literature reviewed. Students' gender differences toward HIV/AIDS were discussed in the study. Influences of students' place of residence toward HIV/AIDS were also examined. The population comprises of 47,000 subjects' who were consisted of undergraduate students'. These students were sample from three tertiary institutions selected from Zaria Education zone for the study in Kaduna state.

A sample of 500 students was used in the study. The samples were drawn using random sampling techniques. The instrument used for the study was a questionnaire. It was structured into five sections. Section A is Biodata, B is Knowledge toward HIV/AIDS, C is Attitude toward HIV/AIDS, D is Socio-economic and E is Belief toward HIV/AIDS. The instrument sought for information from the subjects on the basic characteristics being investigated. Experts validated the instruments. The reliability of the instrument was confirmed using pilot study carried out at Ahmadu Bello University.

The data collected were subjected to statistical analysis using one way ANOVA, Pearson Product Moment Correlation

(PPMC) and t-test analysis. Statistical analyses were based on the use of computer package for social science (SPSS). This was used to analyse the six hypotheses. Moreover, as Behrend (1954) has argued, in analyzing data, the most efficient and the same time simplest available method, which is appropriate to the subject matter, should be used.

Result of the findings was also subjected to necessary interpretations and it was meant to apply to the contemporary situations in our society. This intended to contribute to the social implications that affect the students and their existence. The result was also meant to proffer solutions where necessary and to make adequate contributions towards improving the prevailing circumstance.

The researcher believes that the recommendation in this study will go a long way in helping to correct the social ills of HIV/AIDS.

5.4 Recommendation:

Because of the findings and conclusions reached in the study, the following recommendations were made:

1. AIDS education should be made part of the General Studies or Foundation Studies courses in various academic levels of

tertiary institutions. It should have strong influence on students GPA and they should be required to take the course and pass it before graduating.

2. Given the present lack of curative drug for AIDS, the emphasis must be on education, prevention and research between married and single students' in our tertiary institutions.
3. Community and Non Government Organizations (NGOs) need to provide loans/grants to students, particularly those students' from low socio-economic status, to enable them become self reliant through Income Generating Activities (IGA) in order to alleviate poverty which is the major cause of HIV/AIDS transmissions.
4. Open discussion about HIV are still rare in our institutions of higher learning, this should not be so. A day should be set aside as a special AIDS day in each semester for a general awareness on HIV/AIDS; where related issues should be discussed among students. This will help students understand how to protect themselves from the epidemic especially in the area of gender differences.
5. Enlightenment campaigns on the spread and effect of HIV should be organized by the counseling centre of our

institutions of higher learning in collaboration with other agencies like Ministry of Health as part of education of the youths.

6. There should be a specially designed functional counseling unit for HIV/AIDS in institutions of higher learning. Such move will drastically improve students knowledge, attitude and belief, and consequently increase their fear in engaging in risky behavior toward the spread of HIV infection.

REFERENCES

Abidemi, A.S. (200). HIV/AIDS Awareness and Sexual Behavior among Young people in Nigeria. Ahmadu Bello University, Zaria. Unpublished Ph.D Desartation. PP. 2-3.

Ada, M. and Ikechi, I. (1987). "The deadly side of sex". This week. Volume 3 (ii) PP.16-20.

Adewale, H. (1990). "The fact Nigerians must know". The Nigeria standard. 1st February. Kaduna.

Alutu, A.N. (2002). Assessing Nigeria University students' knowledge about HIV/AIDS. Ambrose Alli University, Ekpoma, Nigeria. (Home page on the internet) PP.208.

Agrawal, H.K. (1999). Knowledge and attitude to HIV/AIDS school pupils and trainee teachers in Udupi District, Karnataka, India. Pub. Ann Trop Pediatr. PP.143-149.

Awosika, F. (1991). "AIDS is not sexually developed". African concord Vol. 7. No. 41 PP. 36-37.

BBC News (2002). "Aids Epidemic still in Early Stages" World Edition: Health, 2 July.

Bello, C.S. (1991). Sexually Transmitted Disease in Africa: Syphilis a continuing probe. England. Volume 13 (5), PP. 123

Bello, I. (2007). The Origin of HIV/AIDS. New Nigeria news paper, 9th March 2007. PP. 3

Brown, L.K. (1990). Differences in AIDS knowledge and attitude by grade J. School Health. P.270-279.

Dralobu, J. (2007). Factors Leading to Adolescent Vulnerability to the HIV/Aids/Stds Infection In Moyo District, Uganda. (Home page on internet), 6th July 2007. PP.1-7.

Eghieye, F. (1995). "How to prevent AIDS". Health waves, Abuja. Nigeria; Vol. 2. PP.5-6.

Fabiyi, A.K. (1993) An Assessment of the Knowledge of Aids of Undergraduates. Obafemi Awolowo University, Ile-Ife, Nigeria: Nigeria Medical Practitional. (Home page on internet) PP.14-17.

Goddy, C. (2000). Teachers Effectiveness in the Selection of Strategies for Treating Behavioral Problems. Ahmadu Bello University, Zaria. Unpublished M.ed Thesis, 2000. PP.7

Gray, L.A. (2007) Knowledge, Attitude and Beliefs About HIV/AIDS among Women Students at an Indian University (Home page on the internet), 6th July 2007. PP. 1-2.

Green, M.S. (1991). Differences in general knowledge of AIDS prevention among Isrealis aged 18-19 years. Eur, J. pub. Health. PP.75-78.

Gupter, R. (1994) In ICRW (2001) Effective Communication between partners: Aids and Risk Reduction for Women. (Home page on the internet), Vol.8 No.1, July 12th 2000. PP.1-4.

Kerlinger, F.N. (1973), Foundations of Behavioral Research. London: Holt, Rinehart and Winston.

Kerlinger, F.N. (1979), Behavioral Research. (2nd Ed.) New York: Holt, Rinehart and Winston.

Krejcie and Morgan (1970), "Choosing Research Sample". Educational and Psychological Measurement. PP. 607-610.

Laah, G.J. (2003). The Demography and Socio-Economic Effect of HIV/AIDS in Kaduna state. Ahmadu Bello University, Unpublished Ph.D Desertation, 2003. PP. 91-95.

Lovell, K. (1973). Educational psychology and children. Pub. Hoker and Stoughtou, London.

Lucky, W.O. (2000). HIV/AIDS: Knowledge, Attitudes and Beliefs among University of Botswana Undergraduate Students'. (Home page on the internet) June 2000. PP.1-3.

Mamman, M. (2004). Lectures notes in M.ed statistics class. Zaria.

Merakou, K. (2002). Knowledge, attitudes, of HIV/AIDS prevention in schools. Eur, J. public health. PP.90-93.

Mohammed, A.I. (2001). Effects of parental Background on Psycho-Social Problems of Almajirai Pupils in Traditional Quranic Schools in Kaduna State. Ahmadu Bello University, Zaria. Unpublished Ph.D Desertation, 2001. PP.7-99.

Momodu, M.O. (1998). School Based AIDS Education Programme. Ambrose Alli University, Ekpoma, Nigeria. (Home page on internet) P.209.

Mukherjee, A. (2004). Educational Psychology. Calcuta: K.P. Basu Publishing Company, India.

NARHS, (2003). National HIV/AIDS and Reproductive Health Survey. Federal Ministry of Health (FMOH) October 2003. PP.9-29.

Nigeria Foremost Health Jounal, (2003). High Prevalence of HIV/AIDS among University Students'. Vol.25 No.6 PP.2-6.

Ngozi, U. (2007). HIV/AIDS prevalence and the Nigeria Society. (A paper presented at a workshop for media Executives in Umuahia) New Nigeria, 2007. PP.3

Omoteso, B.A. (2004). Perception of HIV/AIDS as Correlation of Attitude Towards HIV Infected Students among University. Obafemi Awolowo University, Ile-Ife, Nigeria. (Home page on internet), 2nd July 2004. PP.1-4.

Opolot, A.J. (2007). Economic and Cultural Factors Leading to Risky Behaviors Among the Gisco Community. (Home page on the internet), 24th July 2004. PP.1.

Oyaziwo, A. (2005). Assessing Nigerian University Students' Knowledge About HIV/AIDS. Niger Delta University (Home page on the internet), 20th April 2005. PP.2.

Rose, M.W. (1988). Distribution of knowledge of AIDS: a national study. Soc. Sci. Medicine. (PubMed). PP.275-279.

Rich, J.A. (1996). Preferred sources of AIDS information, risk perception among inner-city community college students. (Pub.Med) PP.87-93.

Rubin, S.A. (1992). Changes in AIDS related risk behaviour relationship to knowledge and experience concerning HIV infection. Pediatrics. P.89-90.

Shabu, L.T. (1997). Influence of Self-Esteem on Psychosocial effects of Acquire Immun-Deficiency Syndromes of Benue State. Ahmadu Bello University, Zaria. Unpublished M.ed Thesis, 1997. PP.4-34.

Sikand, A. (1996). AIDS knowledge, concerns, behaviour changes among inn students. J Adolescent Health. (PubMed). P.325-328.

Tilly, G. (1992). Care of person with AIDS in the community. Lagos, ZAT-TIONTO printing.

UNAIDS (2005). Report on the Global HIV/AIDS Epidemic. (Home page on the internet), Updated 9th April 2005. P.6-7.

UNAIDS/WHO, (2007). Women and AIDS. (Home page on the internet), 6th July 2007. PP.1-5.

UNMIL, (2007). Dangers of HIV/AIDS and Prevention Methods. (Home page on the internet), 6th July 2007. PP.1-5.

UPE, (1981). Foundation of educational thought and practice. Pub. Longman Nig. Ltd.

Uwalaka, E. (2002). Impact of Knowledge, Attitude and Belief About AIDS on Sexual Behavior Change Among College Students in Nigeria. University of Nigeria, Nsuka. (Homepage on theinternet), PP.5-7.

APPENDICES

Appendix 1

Knowledge, Attitude and Belief Questionnaire (KABQ)

I am going to ask you questions, some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form and will never be used in connection with any information you disclose.
Before going to the inventory in other sections please, provide the information in section "A".

SECTION A:

Background information (tick as applicable)
a. Institutions: (1) A.B.U Zaria
(2) F.C.E Zaria
(3) N.B.P Zaria

b. Sex of respondent: 1. Male 2. Female

c. Age: (1) 15---20 (2) 21---25 (3) 26---30 (4) 31---35 (5) 36---40

d. Present level: (1) 400L (2) HND II (3) 100L (4) OND I (5) NCE I

e. Marital status: (1) Married (2) Single (3) Divorce

f. Residence: (1) On campus (2) Off campus

Reflect your opinions on the following: Knowledge, Attitude and Belief as well as Socio-economic of undergraduate students toward HIV/AIDS. Please check responses rated 1-5 in each item and tick correctly as it appeals to you.

1 SD = Strongly Disagree

2 DA = Disagree

3 NS = Not sure

4 A = Agree

5 SA = Strongly Agree

S/No	SECTION B: KNOWLEDGE TOWARD HIV/AIDS	SA 5	A 4	NS 3	DA 2	SD 1
1	I am aware that HIV/AIDS has no cure.					
2	I have very good knowledge of HIV/AIDS.					
3	My knowledge on the symptoms of HIV/AIDS makes it easy for me to identify an AIDS victim.					
4	I am aware that the major way of contacting HIV/AIDS is through sex.					
5	I know about HIV/AIDS but I have more than one sex partner.					
6	I aware of condom as a preventive measure.					
7	I am aware that condom is not 100% safe.					
8	I am aware that HIV/AIDS has claimed millions of life world wide.					
9	I am aware that one cannot contact HIV/AIDS through hand shake.					
10	I am aware that the major way of contacting HIV/AIDS is through sex.					
	SECTION C: ATTITUDE TOWARD HIV/AIDS	**5**	**4**	**3**	**2**	**1**
11	I do not want to relate to my mates who have HIV/AIDS.					
12	I do not care about issue concerning HIV/AIDS.					
13	I feel that student with or any one with HIV/AIDS should seek for assistance.					
14	I feel that any one with HIV/AIDS deserve what he/she is suffering.					
15	I feel that the authority is given too much protection to HIV/AIDS patient.					
16	I feel that students living with HIV/AIDS suffered emotionally.					
17	I feel that student who have HIV/AIDS should not be allowed to mix with others.					
18	I feel that students on campus are frequently involved in rape cases.					
19	I feel that students who are off campus are more expose to extensive relationship that makes it easy for them to be more involve in sexual activities.					
20	It will be stressful if one is identified as					

	AIDS career.					
21	I am willing to eat from the same dish with students who happen to be HIV/AIDS victim.					
22	I will accept it in good faith if identified as AIDS career.					
	SECTION D: SOCIO-ECONOMIC	**5**	**4**	**3**	**2**	**1**
23	Some of my mates engage in commercial sex behaviour because they want to make ends meet.					
24	Some of my generally engage in frequent sexual activities because of their poor background.					
25	Self sponsored students are in danger of engaging in an unwanted sexual activities.					
26	Some of my mates engage in order to solicit favours from teachers and others.					
27	Students poverty level has nothing to do with HIV/AIDS.					
28	Poor students are more vulnerable to HIV/AIDS, when compare to rich students.					
29	My access to money makes me live a reckless life that could expose me to HIV/AIDS.					
30	Student from rich or poor family can be HIV positive.					
	SECTION E: BELIEF TOWARD HIV/AIDS	**5**	**4**	**3**	**2**	**1**
31	I believe that HIV/AIDS is real.					
32	I believe in the use of condom as a preventive measure.					
33	I believe sex is the major rout of contacting the disease.					
34	I believe that HIV/AIDS can easily be acquired by unmarried students than the married ones.					
35	I don't believe it is necessary for me to go for HIV test.					
36	My upbringing has totally formed my belief on sexual activities.					
37	I believe in marrying someone older than me .					
38	I do not believe that poverty is an excuse in engaging in an indiscriminate sex.					
39	I believe that total abstinence from sex will save someone from the disease.					

Appendix 2

Department of Education,
Psychology Section,
Ahmadu Bello University

5th May, 2006.

The Director,
Academic Planning Unit,
Ahmadu Bello University,
Zaria.

Dear Sir,

APPLICATION FOR RESEARCH INFORMATION

I hereby write to seek information on the entire undergraduate students' total population in Ahmadu Bello University, Zaria. This is to assist me on my research work title “HIV/AIDS: Knowledge, Attitude and Belief of undergraduate students”.

Thanks for your anticipated assistance.

Yours faithfully

Bello Yahaya B.
M.ED/EDUC/41560