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A STUDY OF SOCIO-ECONOMIC CONSEQUENCES OF LIVING WITH HIV/AIDS IN LAGOS STATE

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B.Sc (Hons) GEOGRAPHY (IFE)
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I certify that this research was carried out by Adeyemi Ezekiel Oluwagbemiga in the Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife.

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Supervisor and Head
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DEDICATION

I dedicated this work to almighty God and all who have contributed to the success of this work.

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ABSTRACT

The objectives of the study were: (i) to examine the economic implications of living with HIV/AIDS. (ii) to examine the effect of living with HIV/AIDS on household support system. (iii) to evaluate the perception and attitudes of people towards people living with HIV/AIDS. (iv) to assess the sexual behaviour of people living with HIV/AIDS and its implication for the spread of the disease.

The study was carried out in Lagos State. Triangulation method was used for the data collection. Quantitative and qualitative data were collected. A multi-stage random sampling procedure was employed in administration of 1358 questionnaires to the general populace. For qualitative data, Focus Group Discussion (FGD) was used to collect information from people affected by AIDS (PABA), while In-depth interview was employed to collect information from 188 people living with HIV/AIDS through support groups in the State. The data collected from this survey was subjected to three levels of analysis, univariate, bivariate and multivariate analysis. The tools of analysis were logistic regression and ordinary least square regression which were employed to determine the relationship between dependent variables (extramarital sex, condom use and accepting status) and the selected independent variables.

There is high-risk sexual activity in the study area. Among the people living with HIV/AIDS, 66% of females and 44% of males are in age group 21-24 years. Finding also shows that older

people are increasingly being infected with HIV/AIDS. The study shows that HIV/AIDS is bi-modal in its distribution with peaks in both the best educated and the poorest segment of the population. The findings further revealed that large numbers of older people are assuming responsibility for bringing up the children of the infected persons and the orphans of those killed by the virus.

Based on the findings the study suggested that people should be educated on stigma and discrimination regarding people living with HIV/AIDS. It was concluded that poverty should be addressed since the struggle to survive everyday overshadows attention and concern about a virus that does not demonstrate any immediate harmful treat until it has a visible presence manifested by illness and death.

KEY WORDS: Socio-Economic Consequences, HIV/AIDS, Sexual Behaviour and Contraceptive use.

CHAPTER ONE

1.1 INTRODUCTION

Since the first cases of Acquired Immune Syndrome (AIDS) were identified about twenty years ago, a lot has been learnt about modes of transmission of the virus. However, it remains a major problem to human kind. Neither vaccines nor drugs assured an effective treatment for HIV/AIDS. The pandemic continues to grow and to affect millions of people worldwide, particularly the poor in the developing countries where ninety-five percent of cases are concentrated (UNAIDS, 2002). The global HIV/AIDS epidemic killed more than 3 million people in 2003, and an estimated 5 million acquired the human immunodeficiency virus (HIV)—bringing to 40 million the number of people living with the virus around the world. By 2010, sub-Saharan Africa will be home to some 50 million orphans, and more than a third will have lost one or both parents to AIDS. The horrifying situation is that 70% of the people infected globally are from the sub-Saharan Africa (UNAIDS, 2004).

Young adults (15-49) years especially women display high rate of infection from Sexually Transmitted Diseases (STDs) to Human Immunodeficiency Virus (HIV). Young adults often lack information and resources to protect them. In 2001, women accounted for 42% of newly infected people and more than 50% of AIDS related death since the beginning of the pandemic in the early ‘80s. In countries where young people account for 60 percent of all new infection,

infected young women outnumber their infected male peers by a ratio of 2: 1. (UNAIDS, 2002). This is alarming since women bear the main burden of care of family members with HIV/AIDS. The infection impacts on women's health, physical and mental well-being, raises the risk of mother to child transmission, affects their ability to be mothers and limit their educational and employment opportunities (UNDP, 1999).

HIV/AIDS has severely undermined the development of many countries in terms of individual sufferings and loss as well as knock-out effects on the families, communities, economies, medical services, businesses, public services and society as a whole (WHO, 2000). At the micro level, household earnings, savings and disposable income are likely to fall with greater numbers of people facing the burden associated with HIV/AIDS care and treatment. In Rwanda, households with one HIV/AIDS patient spend, on average, 20 times more on health care annually than households without an AIDS patient (UNAIDS, 2001). Only a third of such households can manage to meet these extra costs. A study of three countries (Burkina Faso, Rwanda and Uganda) has revealed that AIDS will not only reverse efforts to reduce poverty, but will increase the percentage of people living in extreme poverty from 45% in 2001 to 51% in 2015. Loss of income, additional care-related expenses, the reduced ability of caregivers to work, mounting medical fees, and funeral expenses collectively push affected households into poverty (UNAIDS, 2002).

At the macro level, the epidemic has impact on the national economic growth in a number of countries. For example Tanzania has experienced a 15% to 25 % fall in Gross Domestic

Product (GDP) as a result of funds for the provisions of basic health care and prevention services. In 1991 in Rwanda, an estimated 66% of public health expenditure was for HIV/AIDS patients (World Bank, 1997). Government revenues are reduced by these health costs. Such costs slow investment in employment creation and capital-intensive sectors. In 2001, the Nigeria Government launched a US $240 million HIV/AIDS Emergency Action Plan. This money could have been budgeted towards infrastructural development than on curbing the spread of the disease.

By the year 2002, AIDS-related increases in mortality are predicted to reduce workforce globally by 11.5 million people and some African workplaces will fall by as much as 20% of existing levels (UNAIDS, 2000). Productivity and profitability are core concerns for enterprises. The epidemic hits productivity mainly through increased absenteeism, organizational disruption, and the loss of skills. Given the proportion of adults infected with HIV and dying from associated diseases in Africa, it is inevitable that the business sector will feel the cost. Some companies in Africa have already felt the impact of HIV on their bottom line. This has affected their productivity and the profit of the company.

The sub-Saharan African region is plagued with incessant armed conflicts and inter-tribal wars: Angola, Democratic Republic of the Congo, Lesotho, Rwanda, Burundi, Liberia and Sierra Leone. These have resulted into the use of military and peacekeeping services. Since military and peacekeeping services often involve lengthy periods spent away from home, service men

often look for ways to relieve loneliness, stress and the building up of sexual tension. They are usually severely affected by the spread of AIDS as a result of their relationship with infected individuals in areas of conflict. The military can have impact on the general population's exposure to HIV, through sexual relationships with commercial sex workers, and through rape in times of conflict. Rape has been a weapon of war since time immemorial. It is most often used to humiliate and control the behaviour of civilian populations or to weaken an enemy by destroying the bonds of family and society (UNAIDS, 2000). Women raped by military personnel suffer not just immediate physical injuries and the risk of pregnancy, but are also exposed to a far higher risk of HIV and other sexually transmitted infections than they would have been, through other unprotected sex.

Armed forces' readiness can also be compromised by HIV/AIDS. Preparedness will also be affected as the skills and experience of highly trained individuals are lost due to AIDS and its opportunistic infections.

Education is an essential building block in a country's development. In areas where HIV infection is common, HIV–related illness is taking its toll on education in a number of ways. First it is eroding the supply of teachers and thus increasing class sizes, which is likely to affect the quality of education. Secondly it affects the family budgets, reducing the money available for school fees and increasing the pressure on children to drop out of school. It has been established that a decline in school enrolment is one of the most visible effects of the epidemic. The contributing factors include; the removal of children to take care of the parents or family

members and inability to afford school fees owing to the death of the parents. Research carried out in South Africa shows that the numbers of pupils enrolled in 2001 in parts of KwaZulu Natal Province was 20% lower than in 1998. This is associated with the impacts of AIDS in the country (UNAIDS 2002).

AIDS is also hampering the ability of education systems to perform its statutory functions, as more teachers succumb to the diseases. Studies in Zimbabwe have shown that 19% of male teachers and 29% of female teachers were infected with HIV (Booyle, 2001). The loss of teachers and administrators will directly affect the quality of education. The costs associated with training new teachers and hiring substitute teachers will also strain budget and crowded investment in infrastructure. Looking at the various impacts HIV/AIDS has on different sectors of the economy and nation as a whole, adequate knowledge of the impact of HIV/AIDS is necessary for effective national strategic planning. Hence, this study is primarily concerned with assessing the socio-economic consequences of living with HIV/AIDS.

1.2 HIV/AIDS IN NIGERIA.

Nigeria with a population of about 126 million people represents about one-fifth of the total African population (National Population Commission projection 2003.) The first HIV-positive person was identified in 1986 as a sex worker from one of the West African countries.

This discovery led to an erroneous belief among the general population as well as government officials that the disease was foreign and could not affect Nigerians (Caldwell, Orubuloye and Caldwell 1992). Subsequent developments in the last sixteen years have proved that the assumption was wrong. The results of the November 2003 Sentinel Survey show that HIV prevalence in the country has increased significantly among the general population from 1.8 percent in 1991 to 5.8 percent in 2002 of the adults population. This indicates that about 5% of the total population has already been infected with HIV. This means that 2.6 million adults are living with the HIV (Federal Ministry of Health, 2003).

Nigerians in policy arena and academia in the early eighties denied the presence of HIV infection in the country, which probably delayed the country from quickly, and appropriately reacting to the surging wave of the epidemic as was done in some other African countries. The high-risk groups in Nigeria with higher prevalence of HIV than the general population are commercial sex workers (CSWs), people infected with sexually transmitted infections (STIs) and long distance drivers. The prevalence rate was 15.1 percent for STDs patients and 34.2 percent in CSWs. The most severe impact of the epidemic has been on adults in their sexually active and economically reproductive year (15-45 years of age). The prevalence rate among young Nigerian girls 15 to 24 years is double of their male counterparts. (NACA, 2003)

UNAIDS (2000) explained that the HIV prevalence rate among Nigerian girls by the end of 2002 was in the range of 4.35 to 5.89 compared with 1.68 to 3.35 for boys in the same age

range. Urban and rural areas are affected and were clearly shown in 13 out of the 36 states. Northwest and Southwest regions have the lowest rates of 3.2 percent and 3.5 percent respectively, while the North-Central zone with a rate of 7.0 percent was the highest. In areas like Enugu State, the mean HIV prevalence had increased from 2.4% in 1995 to 16.8% by 2002, an increase of more than 700%. Similarly, eight other areas in the country had HIV prevalence rates greater than 10 percent (NACA, 2003).

The socio-economic impact of this epidemic on the Nigerian society has not been documented. However, it is becoming apparent that the already fragile health care delivery system is being overloaded. There are also more reported cases of monoparental families and orphans. This is one of the reasons why National Committee on AIDS was inaugurated by President Olusegun Obasanjo.

The president in his address vowed that " we will not allow our country to be overwhelmed by HIV/AIDS" (UNAIDS 2001). President Bush during his visit to Nigeria on 10th July, 2003 also promised to assist in the fight on AIDS. Hence, it is assumed that the projected impact will have disastrous consequences on the population of Nigeria if the problem is not quickly addressed

1.3 JUSTIFICATION OF THE STUDY

The spread of HIV/AIDS is different from that of other epidemics which have occurred in human history, owing to the fact that it touches sex and death, and remains hidden for much of

the time. The latency period on average is 10 years for HIV to reach full blown AIDS and patients need long-term care and support. Sporadic rate of spread of the disease is another factor that makes it different from other diseases witnessed in the recent times. In 2003, one in six were new infections acquired during previous 12 months and there were 3 million deaths (including half a million children) previous year (UNAIDS, 2004).

It now causes more deaths than any other infectious diseases, having overtaken malaria and tuberculosis. HIV is the fourth biggest killer in the world (after heart disease, stroke and respiratory diseases) and has become the single largest cause of death in Africa (Martlin and Spence, 2000). It has become a social catastrophe in Africa especially in sub-Saharan Africa. HIV/AIDS turn children into orphans, women to widows and weakens the breadwinner. In addition to its appalling human consequences, it weakens societies, destroys productive forces, reduces life expectancy, and demolishes social structures (UNAIDS, 2002). HIV/AIDS is not only a terrifying illness; it is also a major challenge to development.

HIV/AIDS and the inaccessibility of available means to prevent and treat it, is a showcase of the disastrous human consequences of a world characterized by an unequal and unfair distribution of resources. It is clear today that HIV is a social and development problem. Fighting the most complex diseases like this requires constant re-appraisal of strategies in the light of new knowledge. It is based on this that there is need to examine the socio-economic consequences of the diseases in the society. Studies have shown the heterosexual nature of

people, the behavioural attitudes and knowledge about HIVAIDS infection and transmission in the country

Available studies also revealed that transmission of HIV is mainly as a result of multiple sexual partners in both heterosexual and homosexual relationships (Sewankambo *et al* 1987, WHO 1990, Jinadu and Odesanmi 1993, Jeremiah 1997, Orubuloye *et al* 1999, Sewardda *et al* 1999,). The major route of HIV infection in sub-Saharan Africa is heterosexual intercourse, estimated to account for 93% of all adult cases, followed by vertical transmission and blood transfusion. Due to the major route of transmission in the region, it is primarily concentrated in the working-age population (aged 15 to 49 years), placing a disproportionate burden on an age group with critical social and economic roles. In Africa, the epidemic places a greater burden on women who experience more infections at an earlier age than men, with a consequent greater loss of healthy years of life and a greater share of the burden of care.

Horizons, (2001) explained that most of the people affected by HIV are usually men and women in their most productive and reproductive years. They eventually leave behind children and dependants when they die. Thirty-three percent of children born to HIV/AIDS mothers will probably be infected with HIV at birth (UNAIDS, 2001). This means that over two thirds of the children of HIV infected mothers even if they may be lucky not to be infected at birth, will become orphans before school age. This implies that the much gain in lower infant mortality

will be eroded if no adequate measures are taken to curtail the impact of this disease with the nation.

There is need for more information on the socio-economic consequences of this disease as little or nothing has been done in this area, given the heavy burdens the HIV/AIDS epidemic places on women children and relatives. By killing productive adults who are the key family providers, HIV/AIDS shatter social networks that provide households with community help and supports. Survivors are left with few relatives upon whom to depend. The consequences of modernization and present day economic realities have eroded this traditional safety net for many Africans. The support of the extended family kinships no longer exists in many countries. Yet, some of the rights intrinsic to kin relationships of the past are still sometimes in place, but without the obligation they entailed. Property grabbing commonly takes place these days where relatives of the deceased may emerge to take possession of his property, not offering the widow and children the care and support that were part of this custom. The widow and her children are therefore often left dispossessed (Yamba, 2001).

The orphans are left to take care of themselves. With regards to children, the UNAIDS Report on the Global HIV/AIDS epidemic reveals that 83 percent (or 1 million) of the 1.2 million children currently infected by this epidemic, now live in Sub-Saharan Africa. More tragic, yet is the rate at which infections among these children are increasing. Of the approximately 4 million Africans exposed to the virus in 1998, 530,000 (13 percent) of them were children.

With no access to sophisticated medical care, these children have little chance of surviving [UNAIDS, 1999].

The family, which is the agent of socialisation, has been dissolved due to the presence of the disease within the households, as parents die and children are sent to relatives. It is pertinent to pose these questions: Will the family be able to act as the agent of socialisation in this dispensation of HIV/AIDS? Can social relationships and family ties still remain strong in the urban centres with the sporadic rate of transmission of this disease? What are the impacts of this disease on child labour? These are some of the questions this study attempts to answer.

Children are now facing problems from the infection, being orphaned and left to suffer untold psychological effects. This is because of the abuse, alienation, stigma and discrimination which are likely to be borne by individuals associated with the disease. Such pressures imply that children may drop out early from school, forcing them to become providers for themselves and their families. In a study in Thailand, children are removed from school to take care of ill family members and to regain lost income. Families often remove girls from school to take care of the sick relatives or assume other responsibilities, jeopardising the girls' education and future prospects.

The elderly are bearing an increasing burden as a result of care of infected people, orphaned children and remaining in the work place for longer period. (Sowell *et al* 1997). Child labour

and street children trading will become more rampant if the impact of the diseases is not properly addressed. Extraordinary efforts are needed to provide for children orphaned by the epidemic, especially in the form of measures that afford them the access to education, food, health care and other social support. The effects of the epidemic on the children must be first identified.

HIV/AIDS is no longer restricted to cities. The disease is now spreading at an alarming rate into rural areas. It affects the farming population, especially people in their most productive years. Agriculture is the mainstay of the economy of the African countries. Studies have shown that rural subsistence household and farmers are often more affected than the urban families. United Nations Food and Agriculture Organization (FAO) reported in 1999 that seven million farm workers have died from AIDS-related causes since 1985 and 16 million more expected to die in the next 20 years. Agricultural output especially of stable products cannot be sustained in such circumstances. The danger of widespread food shortages and hunger is real. In Burkina Faso, 20 % of rural families are estimated to have reduced their agricultural work or even abandoned their farms because of AIDS (UNAIDS, 2001).

Although interrelations between the epidemic and overall development have been acknowledged, the linkages to agriculture have received less attention because the epidemic was perceived as being largely urban. In general, studies tended to ignore the urban-rural movement, especially during the festivals, when male adults engaged in sexual activities with

the village girls and women in exchange for money. This increases the spread of the diseases from the urban and rural areas and vice-versa. The long term effect of this is a reduction in food production in the rural areas when the active members of the community become infected with HIV.

AIDS is now affecting population elements in sub-Saharan Africa. It is changing mortality and fertility rates, reducing lifespan and population growth. The increased mortality rates have had substantial impact on the nation. Looking at the attitudes of men, and the population sub-group that HIV/AIDS is affecting, there is need to examine the consequences of this disease on the families, society and especially on the nation.

1.4 OBJECTIVES

The general objective of this study is to examine the socio-economic consequences of living with HIV/AIDS and its implication for the spread of the disease within the nation.

The specific objectives are to

- examine the economic implications of living with HIV/AIDS.
- examine the effect of living with HIV/AIDS on household support system.
- evaluate the perception and attitudes of people towards people living with HIV/AIDS.
- assess the sexual behaviour of people living with HIV/AIDS and its implication for the spread of the disease.

1.5 REPORT PRESENTATION

The thesis is divided into nine chapters. Chapter one consists of the background of the study, the statement of the problem, justification of the study, and objectives of the study. Chapter two presents literature review, conceptual framework and research hypothesis. The methodology is discussed in chapter three. Chapter four describes the socio-economic characteristics of the respondents such as age, sex, occupation, place of residence etc. In chapter five factors influencing HIV/AIDS transmission, living with HIV/AIDS and sexual behaviour, sexually transmitted diseases, treatment seeking behaviour, behavioural attitudes towards STIs and bivariate analysis of some variables are evaluated. Chapter six is on multivariate analysis of independent variables such as age, sex, education, age at first intercourse and dependent variables (ever used condom and ever had extra marital relations). Chapter seven focused on the social impacts of living with HIV/AIDS, while chapter seven is on the economic consequences of living with HIV/AIDS. Chapter nine, highlights the major findings, summary, conclusion, policy implications and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

KNOWLEDGE, ATTITUDES AND PERCEPTIONS ABOUT HIV/AIDS

Misconceptions regarding HIV/AIDS and other STDs contribute a limiting factor to behavioural change. UNAIDS (2002a) examined three factors that influence individual risk. These are cognitive, attitudinal and behavioural. Cognitive factors are those that relate to how and what individuals know about sex and sexuality, HIV risk and risk taking, HIV/AIDS - related care. They include women's and men's ability to understand HIV risk and the information that would allow them to reduce their risk. Attitudinal factors include people's feelings about situations. They include feelings about HIV/AIDS, attitudes towards those infected and the view about the culpability of the social group. In Uganda, Caldwell *et. al,* (1992) observe that 'The fear that AIDS might be caused by witchcraft or sorcery may easily lead people in affected areas not merely to ignore and fail to discuss it, but to censor it in their own minds'.

There was also a widespread belief in Uganda that people who have lost weight cannot be infectious, amongst men and women (Schoeff 1988, Nyamwaya 1996:8). Langford and Raithatha (2000) in their studies about perceptions of HIV/AIDS among students in Norwich observed that the respondents did not feel personally at risk from HIV, believing that HIV affected other people and not themselves or their peers, and this was reflected in their stated behaviour. Some of the students believed that only certain groups of people, for example

homosexuals and prostitutes, were likely to become infected with HIV. The use of personal protection (condoms) against the risk of contracting STDs appeared not to be influenced by concern about HIV and AIDS; rather avoiding pregnancy was found to be the main reason for using condoms.

The respondents felt they were not well informed about HIV/AIDS, particularly the emotional and social aspects of the disease. The trust in partners was reported as a reason for believing a partner could not be HIV positive, regardless of knowledge of their HIV status. The Indian Council of Medical Research (ICMR 1999) observed that most of the people infected with HIV in India are not aware of their infection. Even if they are aware, they may not disclose the fact to others who are at a high risk of being infected by them. It became clear that although most groups could describe the effects of full-blown AIDS, there was a very poor understanding, even among the teachers, about the nature of the HIV virus and its routes of transmission.

Young people's vulnerability is compounded by their scant knowledge of how HIV is spread and how infection can be avoided. Many millions still have not heard of HIV/AIDS. Many millions of people still harbour misconceptions about the disease. Young women in many countries are far less knowledgeable about HIV than young men.

Setel, (1997) observed that young women's ability to seek information or talk about sex is greatly constrained by strong cultural norms that emphasise the value of virginity. As a result

of these gender norms, girls and women are poorly informed about reproduction and sex. Studies carried out in India found that young women knew little about their bodies, pregnancy, contraception and STDs (Gilks, 1998). This lack of information limits women's ability to protect themselves from HIV, contributing to fears among women about condom use.

Studies also reveal that lack of information about their bodies limit women's ability to identify abnormal gynaecological symptoms that could signify an STD (George and Jaswal, 1995). In cultures where virginity is highly valued, research has shown that some young women practised alternative sexual behaviour in order to preserve their virginity. These may place them at risk for HIV infection. In another study, young unmarried women working in export processing zones in Mauritius report a practice referred to as "Light Sex" (having sex through anus) which is not constructed as being sexual intercourse. Women who practised 'Light Sex' felt they were protecting their virginity and did not perceive themselves to be at risk of pregnancy nor HIV infection (Rowley *et. al* 1990).

Young girls who are virgins are placed at high risk from men owing to the notion that female virginity signifies cleanness and purity and thus freedom from diseases. This is based on an illusion that the mode of transmission is not through sexual intercourse alone, but there are other routes through which people can be infected. These include, using unsterilised instrument, blood transfussion, pedicure and manicure . In the areas of high seroprevalence, it has been reported that older men are seeking out young girls in the belief that, as virgins, they

are free from HIV. A study in Democratic Republic of Congo reported that men chose young and plum girls for sex, assuming they are HIV-negative (Schoeff, 1988)

Although people are aware of the disease, most of them still doubt its existence. Some people believe it is another way of discouraging sexual intercourse. Hogsborg and Abby (1992), in a study carried out in Guinea Bissau, explained that 44% of the respondents interviewed were in doubt if the disease really exists in their country. About 78 percent of those who had heard about the diseases had no idea about the symptoms and the latency period. This has great implications in the spread of the diseases, since an infected person could not be easily identified.

Programmes and research on HIV/AIDS are currently undergoing a shift from focus on women and the risk group to men. The clamour now is to change the behavioural attitudes of men to safer sex. This thinking was behind 2002 ”World AIDS Day” at Barcelona in Spain that men must be involved in this behavioural campaign. But despite the knowledge and the campaign about AIDS, the attitudes of men and belief about death remain the same. Orubuloye and Oguntimehin (1999), in their study about attitude of men to death in the presence of AIDS, observed that there was a general belief that it was not possible for men to confine themselves to one woman over a life time. They also believed that death is preordained. It will come when it is due. It is inevitable. Also, in another study in Uganda, young people reacting to HIV

commented that “AIDS came for people, I am not a tree to be used for furniture and everybody will die anyway’ (Amuyunzu-Nyamongo *et. al* 1999)

Studies have also shown that knowledge about HIV/AIDS will affect condom use. Osho and Olayinka (1999) observed that the greatest proportion of condom users had a good knowledge of the routes for HIV transmission, while the highest proportion of sexually active individuals who had never contracted STIs had a poor knowledge of condom. It was established in their findings that there is a strong relationship between the knowledge of mode of transmission for HIV and perception of AIDS risk in Nigeria.

In a survey in Kenya, nearly half of the young men (21-40 years) had had sex and over two-thirds of the young women had never used a condom. Among these young people, over 40% of the boys and 55% of the girls thought that HIV might be able to pass through a condom, and roughly the same proportions believed condoms could get stuck inside a woman’s body (Ntozi *et. al* 1997). Misconceptions about condoms are not confined to the youths. In a study in Kenya, over half of the parents and guardians of the young people in the study thought that HIV could pass through a condom, and only 48% said condoms were effective prevention against HIV (Horizon, 2000). Carovano (1992) explained that the perceptions of risk of AIDS is generally higher in high risk behaviour groups, large proportion of people who are obviously at risk do not yet perceive themselves to be at risk.

Orubuloye and Oguntimehin (1999), observed that although the majority of the commercial sex workers knew that using condoms protected them from STDs, only one-third were using them regularly. This has a serious implication for the spread of HIV infection in Nigeria. It can be difficult or impossible for sex workers to insist on safe sex, clients might react with violence or simply move on to someone willing to forego a condom. A study in India found out that clients of the commercial sex workers were willing to pay almost double the fee for sex without a condom (UNAIDS, 2000).

In parts of Indonesia, research shows that almost all sex workers know about HIV/AIDS and over three-quarters know it can be avoided by using condoms (ICMR, 1999). Studies among long distance truck drivers have shown that the truck drivers normally have multiple partners. Although they are aware of the HIV/AIDS only few of them normally used condoms (Dominique *et al* 1997, Orubuloye et al 1991, Von 1990). The 1991 study of the truck drivers showed that the drivers reported an average of 6.3 current sexual partners, 12 sexual partners during the previous year and 25 partners besides their wives during their lifetime. Nearly all the drivers knew of STDs including HIV/AIDS and 44 percent had been treated for one or more, only 15 percent used condom on regular basis, primarily with partners other than their wives or regular partner (Orubuloye *et. al* 1993)

However, where knowledge has been substantially increased, 'knowing' is not necessarily 'doing'. Most people do not connect knowledge and risk perception with behaviour. Ntozi and

Ahinbisibwe (1999), explained that the high level of AIDS awareness and fear in the community in addition to favourable sexual attitudes resulted in the decline of AIDS in Uganda.

2.2. FACTORS AFFECTING THE SPREAD OF HIV/AIDS

2.2.1 Poverty

In the early 1980s, as AIDS was just beginning to trickle into the global consciousness, medical doctors and social scientists began an aggressive campaign to combat the HIV virus. Their strategy of preventive knowledge was widely viewed as the best weapon readily available in our admittedly limited arsenal. Seventeen years later, social scientists report that this campaign has largely failed. While studies debate the actual figures, most experts now agree that HIV/AIDS awareness is fairly common among African citizens. Rosenvard and Campbell, (1996), in their report on sexual behavioural changes, explained that public information campaigns about HIV have occurred in many sub-Saharan African countries with high HIV prevalence. While knowledge about HIV/AIDS has resulted in higher levels of awareness, this has not generally been reflected in a consistent reduction of incidence of HIV.

If awareness has not reduced the rate of infection, the question that must still be answered is this: what other factors, apart from HIV-ignorance, are contributing to the high rates of HIV in certain African countries? In answering this question, global health experts have shifted away from the traditional behaviourist model and have sought to find solutions within socio-

economics. It is their contention (after years of observation) that poverty, working together with other factors has created an atmosphere conducive to the spread of the HIV virus.

Campbell, (2001) explained that poverty, underdevelopment and illiteracy are amongst the principal factors contributing to the spread of HIV/AIDS in Africa. On the other hand, HIV/AIDS also increases poverty. The disease drastically increases the burden on health systems, which are already weak due to poor infrastructure, under-funding and overburdened staff. The link between HIV/AIDS and poverty is complicated however, and HIV/AIDS is more than just another serious disease. Whereas diseases like malaria, tuberculosis, respiratory infections and diarrhoea are largely manageable pending economic resources and political will. Other factors complicate the spread and consequences of HIV/AIDS.

Stigma, silence, discrimination and lack of confidentiality undermine prevention and care, and increase the consequences of the epidemic for individuals, families and communities. Furthermore, the link between income, poverty and HIV/AIDS is not straightforward. Botswana, for instance, is one of the richest countries in sub-Saharan Africa, yet it has one of the highest HIV infection rates in the world. Other factors, such as income and gender inequality, are also significant to the spread of HIV/AIDS. For example, women and girls from poor households may be forced into prostitution to increase household income. The bigger the income inequality, the easier it will be for the relatively well off men to pay for such services.

Otti and Rasekoai, (1998), explained that many young girls are forced into prostitution because of poverty. In addition to lacking basic resources, extreme poverty dehumanises the individual to a point where issues of self-esteem and morality become secondary. Although many of these girls are familiar with the AIDS epidemic, the allure of economic security is strong, regardless of the risk to their personal health. [Pianos Institute, 1989]. Older men also seek out ever-younger girls in the belief that, as virgins, they are free from HIV. Girls from low-income families are vulnerable to the enticements of these older men known as "sugar daddies", who offer money or gifts for sex. A study conducted with high school girls in Zimbabwe found that "sugar daddies" paid for school fees and books [Bassett and Sherman1994].

Orubuloye and Oguntimehin, (1999), observed that main reason given by the commercial sex workers for entering commercial sex is that it was lucrative. The majority earned much money than they could in other jobs with their school qualifications. They considered commercial sex work as a stage in life and an opportunity for a period of intensive saving in order to establish themselves for the rest of their lives.

2.2.2 Female Genital Cutting and Widowhood Practices

A number of studies show that traditional practices such as widow inheritance, Polygyny and wife sharing are significant factors in HIV transmission. Irresponsible sexual behaviour and alcohol consumption during funeral rites and other traditional ceremonies are common. The use of alcohol at funerals and other ceremonies increases risk of HIV because it typically

lowers normal sexual inhibitions. In Uganda, funerals and other ceremonies sometimes glorify sex, and offer of women to men during ceremonial times (AfriAfya, 2002). Studies on sexuality in different cultures of Uganda show that women are more vulnerable than men to contracting HIV and other sexually transmitted diseases (STDs) (Ntozi and Ahimbisiwe 1999, Ntozi 1997).

A number of factors that have been identified include, physiological vulnerability, age at marriage, polygyny and female genital mutilation (FGM) (Rosenvard, and Campbell, 1996; Caldwell, 1989). In societies like India, where the epidemic is heterosexually driven, young women are more exposed to the risk of HIV infection than young men for both physiological and societal relationships. This is especially true of women (both married and unmarried) who have sexual relationships with men for socio- economic survival. For some women, a major source of earning is through commercial sex and the *devadasi*s. As tradition, these young adolescent girls from lower socio-economic strata are called “devadasis” when they are given away by the parents to the temple through the practice of theogamy, i.e. being married to gods. After getting this ritual sanctity, they move outside to bigger cities and engage in commercial sex. (ICMR, 1999). This leads to the transmission of the infections in the cities.

Polygamy is seen as a practice that spreads HIV, since one or more of the wives in a polygamous marriage may have additional partners. While marriages in most African cultures start off by a man having a single wife, men enter into polygamous relationships for various reasons. These include, failure of the first wife to have children, poor marital relationships and

conflicts when the wife is old, weak and unable to work effectively (Family Health International, 1993; Rowley *et.al* 1990).

While circumcision is mainly a religious and cultural practice, some people believe that it has some health benefits - mainly because circumcision makes it easier to keep the penis clean. But there can be other health reasons for circumcision too. Some people think that circumcision protects against HIV/AIDS and other sexually transmitted infections (STIs). However, even if one has been circumcised, one is at risk of HIV/AIDS and STIs.

Increasingly, circumcision is being done in health facilities especially in urban centres, but in some place, traditional "surgeons" do it as part of a traditional ceremony. In East Africa, Massai men who were circumcised at the same time share everything, including their wives. All that is required is for the visiting comrade to put his spear outside the targeted hut to announce his presence and he is entitled to the same conjugal rights as the husband (UNDP, 1999). These cultural attitude influence the spread of the disease among women and within the population group. Lack of male circumcision has been mentioned as a possible factor in elevated rates of female-to-male transmission in some part of the sub-Saharan Africa (Cameron, 2000). Studies have also shown from two ecological studies that there is a shrinking positive relationship between those parts of Africa which have high rates of HIV-1 and those that have low rates of male circumcision (Bongaats *et.al*, 1989, Anderson *et.al* 1991).

Female genital mutilation (FGM) is a widespread cultural practice that contributes to HIV/AIDS infection rates among women. According to the YMCA Regional Training Institute in Nairobi, Kenya, 250 girls are mutilated in Africa every hour, many with the same knife. They range in age from 3-day-old babies to women just before their wedding day. This practice has led not only to HIV/AIDS infection, but also caused death, infection, complications in pregnancy, painful sex and urination and lifelong psychological trauma (WHO, 1995).

It has also been noted that widowhood practices may likely influence the spread of HIV/AIDS. Since many widows are HIV- infected and will spread AIDS through sexual networking with other groups, sexual networking of the widow may be through widow inheritance, remarriage, casual sexual partners or prostitutions (Ntozi *et.al* 1999, Tavern 1996,). Studies carried out in Africa indicated that young widows customarily remarried or were inherited by male relatives of their deceased husbands (Kirkpatrick, 1993; Quedrago 1994; Andima, 1994). Similarly, through the common custom of sexual cleansing, the widow had to have sexual intercourse with one of her in-laws in order to appease the deceased husband's ghost (Okeyo and Allen 1994; Kaunda, 1995). In Rwanda, widowers used to have sexual intercourse with an "unweza" (a young unmarried woman) as part of the purification rites. Not only were the customs oppressive but they have facilitated the spread of HIV (Salaka, 1996; *AIDS Analysis Africa*, 1997).

2.2.3 Migration.

One of the most important factors that influence the spread of AIDS is migration. Through population movements of many different kinds, people may be subjected to a variety of health as well as engaging in social and risky behaviour likely to enhance the spread of AIDS (Anarfi, 1993; Prothero, 1977). As men have left their small communities to seek employment in the urban centres, social relationships and familial ties have been weakened. New sexual networks are formed in the city and men find themselves exposed to a variety of STDs, including the highly prevalent HIV virus [Hunt, 1989]. African women's vulnerability to HIV/AIDS is also affected by these migration patterns. Studies show that as men move home to their rural communities, they often return with the HIV virus and end up infecting their wives, who are usually unaware of their husband's urban infidelity. [Tiou S, Norr K, McElmurry, 1995]

Another side effect of the migratory patterns is an increase in the number of households led by women (one-third of all households world-wide [Buvinic and Yudelman 1989] Women are often unable to meet the economic needs of their families. Many of these women are turning to transactional sex in exchange for goods and money.

Many women are economically dependent on men, hence the degree to which they are able to express their own will is often limited. This lack of choice – or lack of power –leads some women to engage in high-risk behaviours, which increase their chance of contracting the HIV virus. Many women believe that the negative economic consequences of leaving the high-risk relationship outweigh the possible repercussions of staying with an infected partner. [George

and Jaswal, 1995]. One visual demonstration of this lack of choice is the "sugar daddy" phenomenon currently being reported in Uganda, Zimbabwe and other countries in the Sub-Saharan region. According to social scientists who have examined this trend, young women are increasingly engaging in high-risk sexual activity with older men in exchange for gifts, money and promises of future provision.

Age and sex composition of most migration streams in Africa make the human contact factor very important in the era of AIDS. Most migrants were likely to be males in the active age group, usually unmarried, or if married unaccompanied by their wives. If the migrant is an autonomous female, she is usually young, unattached and lacking basic skills to compete for jobs in the new destination. This, with the constant and overpowering nature of the sexual appetite in males creates the condition for exchange of sex for favours. In this respect, a female migrant becomes highly vulnerable (Anarfi, 1997).

2.2.4 WAR AND CONFLICT

In a situation of conflict, the risk of sexual violence increases dramatically. There are large numbers of mobile, vulnerable and unaccompanied women who become easy prey for the rapists. Children who survive wars often end up as orphans with no skills to face the challenges in life. Prostitution becomes the most likely way out; particularly for girls and the vicious cycle of HIV/AIDS spread is thus perpetuated. (UNDP, 1999).

War itself offers a breeding ground for HIV infection. The mobilisation of large numbers of young men (already a high –risk group for STDs), the practice of intimidation through rape, and displacement of refugees (a highly vulnerable group) all these factors increase the virus' prevalence. To make matters worse, war is often accompanied by the breakdown of health and educational infrastructures, crippling efforts to minimise the spread of HIV during or following conflict (UNAIDS, 1998). With the military intervention in the war or conflict zones, there is a clear indication for the military to be infected with diseases. Recently, comparative studies of sexual behaviour in France, UK, and USA showed that military personnel have much higher risk of HIV infection than their counterparts in the civilian population. Military personnel on deployment often indulge in risky activities. For example, a study of Dutch sailors and marines on peacekeeping duty in Cambodia found that 45% reported having sexual contact with sex workers or other members of the local population during a five –month tour (UNAIDS, 1998).

2.3 GENDER AND HIV/AIDS

Across the world, there has been a changing pattern of male/female infections. Early cases in many countries were concentrated in male homosexuals and intravenous drug users, but as the epidemic peaks there has been a progressive shift towards heterosexual transmission and increasing infection rates in females. The reality today is that, globally, more women than men are now dying of HIV/AIDS, and the age patterns of infection are significantly different for the two sexes (UNAIDS, 1999)

Beyond the statistics of sex-based differences in infection rates, there are profound differences in the underlying causes and consequences of HIV/AIDS infections in male and female, reflecting differences in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability (Matlin and Spence 2000). In many ways, the inequity that women and girls suffer as a result of HIV/AIDS serves as a barometer of their general status in society and the discrimination they encounter in all fields, including health, education and employment. It is for these reasons that HIV/AIDS is inherently a gender-based issue and needs to be seen in this light if it is to be addressed effectively. HIV/AIDS will only be conquered when the effort to achieve gender equality is successful.

The status of women within the African context should not be seen as an insurmountable barrier to reducing HIV risk. Although gender norms significantly increase the woman's risk of HIV/AIDS, it is important to recognise the diverse factors influencing these norms. In the traditional African family, the ideal feminine attributes include sexual innocence and motherhood with the expectation that the woman becomes a hard working household provider (Orubuloye 2004). In the rural setting, she cared for her children and worked on the fields. Her status depended on her ability to influence the size and strength of her family.

Traditionally, she had little access to such key resources as information, education, employment, income, land, or property. She has little or no power about her reproductive health. In the traditional model, the African woman's status was unrelated to income and

resources, but her lack of economic clout now undermines her position in the culture (Omideyi, 1986; Caldwell, 1989, Papanek, Hanna. 1990; Omideyi, 1990). Due to their position African women have difficulty in saying no to sex or to unprotected sex since they are socially and economically dependent on male partners (Orubuloye et al 1993). Also, due to the limited livelihood opportunities and various forms of gender discrimination and harassment, women adopt sexual 'survival strategies; they "sell" their bodies at the work place, or at school, in order to gain access to resources, security, patronage or protection. This may be aggravated, where women lose their livelihood as they become widows through AIDS (Durrant, 1994)

Scientific evidence shows that women's risk of HIV infection from unprotected sex is at least twice that of men (Webb, 1997). There are more virus in sperm than in vaginal secretions and high concentrations of virus remains in the vaginal canal for a longer time. Women are more exposed through the extensive surface area of mucous membrane in the vagina and on the cervix through which the virus may pass. Teenagers are at greater risk than mature women. A teenager's vagina is not as well lined with protective cells as that of a mature woman. Her cervix may be easily eroded potentially enhancing risk of HIV/AIDS infection. The young women also have immature cervix with a thinner mucous membrane, which secrets lesser amounts of prostate against viral penetration, thus increasing the risk of infections ((WHO, 1990; Reid and Bailey, 1992; Baden and Wach, 1998).

The practice of forcing young girls into marriages sometimes as early age as 12 years is not only traumatic, but also devastating. It is difficult to separate the social and physiological causes, especially when young women who are at particular physical risk are exposed to sexual practices over which they have limited control due to social conditions. For social reasons, women tend to have older male partners, the peak age of new infection is between 15 and 25 years, whereas men tend to become infected 5-10 years later. (WHO, 1995).

It was also observed that young girls who marry older men may end up seeking sexual satisfaction elsewhere. Jeremiah (1997), in a study in Uganda finds out that 37% of sexually active women aged 15-39 years in Uganda are dissatisfied with their sexual relationships. The major reasons are sexual dissatisfaction, alcohol related problems, mobility, infertility and sexually transmitted diseases. Weak sexual drive, impotence, STDs, age, poor sexual styles and biological factors, among others, cause sexual dissatisfaction. A person who is sexually dissatisfied loses interest in the partner and soon looks for a new lover who satisfies her, this has a great implication for HIV infections and transmissions.

Domestic violence reduces women' s sexual control over their exposure to the HIV. In societies where violence is not regarded as an offence, women are in a difficult position to question their husbands about extra marital affairs, negotiating condom use, or refusing to have sex. As awareness of HIV increases, there is evidence that men shift towards younger partners

who are deemed less likely to be infected whereby the greater age difference increases the risk of transmission (Oppenheim-Mason, 1994).

The gender-based norms surrounding sexual behaviour also make the female gender to be more infected than male. Women are thought to leave sexual initiative to men and, or, behave in ways which please men (e.g. use of virginal stimulants), whilst increasing risk to themselves. They are also expected to limit their sexual relations, often to marriage or long-term partnership, while men are often encouraged to express their masculinity and increase their social status by having many partners\lots of sexual experience, increasing not only their own risk of infection, but also that of their monogamous partners (Oppenheim-Mason 1994, and Durant, 1994).

A study of 1,458 childbearing women from Rwanda, found an infection rate of 20 percent among women in monogamous relationships. In Senegal, a study revealed that 50 percent of HIV infected women had monogamous relationships. [Allen, Susan *et.al* 1991; Hamblin and Reid, 1995]. Given the high social value placed on female chastity and monogamy, it is a paradox that for millions of girls and women across the world, sex is the "currency" with which they are expected to pay for all life's opportunities, from gaining admission to overcrowded classrooms to passing examinations, securing employment or a market trading licence, or even crossing a border.

Evidences also revealed how economic necessity compels families to send their daughters to work through agents without knowing that they are sold into sexual slavery. Women and girls are trafficked for the sex trade not only through abductions and false promises of good jobs or marriages, but through argument that women earn more through prostitution (Igbinedon, 2000). Women's low economic and social status limits their power to negotiate the use of a condom, discuss fidelity with partners or leave risky relationships. For most of the women who are vulnerable to HIV/AIDS, research shows that they perceived the negative economic consequences of leaving high-risk relationships to be far more serious that the health risks of staying in the relationship (George and Jaswal, 1995; Morris *et.al* 1987; Heise and Elias, 1995). Research has revealed the situations under which some women are able to reduce their individual risk in a variety of ways. In instances where women are financially independent, they are more likely to be in positions to reduce their risk of infections.

Orubuloye *et.al* (1993), found out that Yoruba women from south-west Nigeria were able to refuse sex without violent consequences if their partners had sexually transmitted infection. In the same vein, as study also from USA shows that African-American and Hispanic women from New Jersey were able to exert considerable power by withholding sex if their partners did not agree to use condom (UNAIDS, 1999). However, for women who lack economic independence and therefore are not able to leave or avoid situation at risk, the only other option available is to attempt to negotiate changes in behaviour of their partners. Studies have shown that women who are aware of their partner's sexual behaviours feel helpless about their

inability to change it, and have cited their fear that trying to do so could only result in disruption of their partnership and jeopardize the physical safety of the woman. Women who raise the issue of condom use run the risk of conflict, loss of support, and violence. (Morgan, 1989; Hunt, 1989; Berger, 1994, Goldstein, 1995; George and Jaswal, 1995; Adeokun and Nalwadda, 1997 ;). It was also discovered that in many instances, sex takes place under the conditions of poverty and overcrowding which make it difficult for women to communicate freely with their partners, let alone negotiate. Men also demand for sex under the influence of alcohol and drugs making negotiation impossible (Goldstein, 1995 and Nabaitu, 1995).

Since disempowerment of women increases their vulnerability to HIV, sexual discrimination experienced by them can ultimately become life-threatening. Negotiations between couples is not a good style of communication since in most instances women cannot decide when or whether to have sex. Gender equity is seen as the key in the fight against AIDS when changes are necessary in both male and female knowledge, attitudes and behaviour. Women need to develop greater esteem and knowledge in order to take more responsibilities for their sexual and reproductive health, free from coercion, discrimination, and violence. Men need to take greater responsibility for their own conduct and recognise the importance of women's health and well being.

2.4. SOCIAL IMPACT OF LIVING WITH HIV/AIDS

The social impact of HIV infection will result from the illness and death of individuals and the consequent effect on the family, community and broader society. The death of an adult female may result in children receiving less care and female children being taken out of school. Reports revealed that one of the devastating impacts of the HIV/AIDS is the increase in the level of orphanhood. (UNICEF, 2002).

By the end of the year 2002, a cumulative total of 13 million children will have lost their mother or both parents to AIDS, and 10.4 million of them will still be under the age of 15. More than 90 per cent of children orphaned by AIDS are in sub-Saharan Africa, and the numbers are increasing daily (UNAIDS, 2002). Families often remove girls from school to take care of sick relatives or assume other family responsibilities, jeopardizing the girls' education and future prospects. In Swaziland, school enrolment has fallen by 36% due to AIDS, and girls were mostly affected. There are now a growing number of destitute, widowed mothers and their children driven from their homes to live on the streets having sold everything in the effort to find a cure for the fathers who have died of AIDS (Blown, 2000).

In a community in Swaziland, the people frequently reported putting physical distance between themselves and persons suspected of having HIV/AIDS, not shaking hand, not sitting next to such people on buses, not sharing food and drinking utensils. These were all stigmas of rejection. The stigmas attached to people living with HIV/AIDS are many: children whose

parents died as a result of HIV/AIDS may be sometimes taunted by other children; they get new social identities where others refer to them as 'children whose parents are HIV/AIDS infected or HIV/AIDS orphan. This limits their social interaction with other children and members of the community because just like their parents, they also keep to themselves. In some situations, some of the children who are infected experience rejection from schools, friends and local communities because of the fear that they may infect others (Altman, 1999, Simms, 2000).

United Nations Children's Fund (UNICEF, 2000) has observed that AIDS affects children long before their parents die. The toll taken by the disease begins during the period of illness, continues through death and bereavement and may likely persist into adulthood if adequate support and protection are lacking. These extremely vulnerable children can suffer myriad of problems and human right abuses: the terrible stress of watching parents fall ill and die, grief for lost family members; a decline in nutritional status; loss of health care; increased demands on their labour; reduced opportunities for education; loss of inheritance; homelessness; discrimination; physical abuse; and sexual abuse, which in turn exposes them to HIV infection.

Center for Disease Control and Prevention (CDC 2001), reports that people living with HIV/AIDS face discrimination and stigma that are associated with the disease and hinder HIV prevention efforts. Stigma affects all aspects of life for people living with HIV/AIDS including housing, employment, and public relationships. Those with HIV/AIDS face social disapproval

regardless of how the disease was transmitted. Case after case reveals the potent reality of discrimination and stigma attached to the disease. In 1998, an 8-year old girl was refused admission to A Girl Scout Troops in New York area because she was HIV positive. More recently, a Virginia boy was denied a sport in a karate class when his instructor insisted his participation would pose a threat to the health and safety of other students in the class. The Supreme Court ruled in favour of the instructor, which reinforced and confirmed many misconceptions around HIV/AIDS transmission (CDC, 2001).

Many people tested positive decide to hide their HIV- status because they are afraid of the social stigma. This can lead to an underestimation of the number of HIV positive persons in an area. A study by a Norwegian Church revealed that people living with HIV/AIDS tend to be stigmatised not only because of their HIV-status, but also because of other qualities related to them; like poverty, gender, race etc (Norwegian Church, 2002). Generally, women are more exposed to HIV/AIDS-related stigma than men. Thus, in many countries, it is common that pregnant women are bound to take HIV/AIDS test when they visit health centres. At the same time because of their concern for personal health, motherhood role, they tend to visit hospital \health care centres more frequently than men. These practices often make women to be the first people to know about their HIV/AIDS status in the family. When this is revealed, some women are blamed for having infected their partners with virus and because of this, they end up by being rejected or excluded from their families. There are instances in Uganda and Kenya where family members encourage a husband who is asymptomatically HIV-positive to leave

his wife with AIDS and find another one. Children from such women are forced out of the matrimonial home (Hamblin and Reid, 1995).

Abandonment by the family members, friends, and neighbours compounded by economic powerlessness and lack of legal rights to property and other productive resources are some of the problems faced by women living with HIV/AIDS. But it was observed that in communities that have been devastated by HIV/AIDS, there is anecdotal evidence that stigma leading to abandonment of women living with HIV/AIDS is on the decline (Hue and Kauffman,1998). Wide spread HIV/AIDS-related stigma and discrimination persist despite the fact that they increase people's vulnerability and, by isolating people and depriving them of care and support, worsen the impact of infection. Indeed they impede every step in an effective response, from prevention to treatment, care and support, and even extend into the next generation, placing an emotional burden on children who may be trying to cope with the death of their parents due to AIDS

(UNAIDS, 2002).

2.5 ECONOMIC AND DEVELOPMENT IMPACT OF LIVING WITH HIV/AIDS

AIDS has created severe economic impacts in areas or countries where its prevalence rate is high. At the household level, effects of HIV infection are obvious: the death of an adult male, who is an income earner, will affect the family access to resources. At the society level, it causes a reduction in the size and experience of the labour force, increases health care expenditure, raises the costs of labour and reduces savings and investment. The economic effects of AIDS are felt first by individuals and their families. They then ripple outwards to firms and businesses and the macro-economy.

The impacts of HIV/AIDS on families have been documented. As indicated above, households suffer decrease in income. This has led to rapid transition from relative wealth to relative poverty in some countries. Research has shown that in two thirds of the families where the father had died, monthly disposable income fell by more than 80%. Loss of income, additional care-related expenses, the reduced ability of the care giver to work, and mounting medical expenses collectively push affected households deeper into poverty (Egal and Valstar, 2000). A study in Cote d'Ivoire revealed that income in affected households was half of that of the average household. This was often the result not only among household members, but because members had to divert more time and effort away from income-generating activities (Bechu, 1998). Most of the households affected are also stripped off of their productive assets, such as land, livestock, bicycle, and cars, making livelihood to become difficult.

A study in Chiang Mai, Thailand, revealed that 41% of AIDS-affected households reported having sold land, 57% used up their savings and 24% had borrowed from a co-operative or other type of locally –run fund(Kiragu K, 2001). Barnett and Rugalema (2001), explained that HIV/AIDS is a huge health problem with profound social and economic implications, especially on food security. Households affected by HIV/AIDS often replace valuable and nutritious crops that are labour intensive with roots crops, which are fast-maturing but less profitable. Household members consume such mainly starchy food and, with lower farm income, cannot easily purchase nutritious food.

Chronic food insecurity and high levels of malnutrition among children, especially orphans, are the likely results of these changing crop patterns. Subsistence agriculture requires the interaction of human, financial, and physical resources, and all adult household members contribute to this interaction in some way. But HIV/AIDS breaks the chain of knowledge transfer and labour sharing between generations. As a result, survivors –notably orphans and the elderly, who cannot manage the family farm due to lack of knowledge, experience, and physical strength often remain malnourished (Barnett and Haslwimmer. 1995).

Since the advent of HIV/AIDS, if one or more family members are affected and die, the entire assets and savings of many families, which are generally meagre before the onset of the diseases, may be completely spent leaving the survivors without any means of support. A study in Kenya has shown that the burden of the socio-economic impact of HIV/AIDS is

disproportionately affecting rural women. More households were found to be headed by AIDS widows than by AIDS widowers. Widows with dependent children became entrenched in poverty as a result of the socio-economic pressures related to HIV/AIDS. Widows lost access to land, labour, inputs, credit and support services. HIV/AIDS stigmatisation compounded their situation further, as assistance from the extended family and the community, their main safety net was severed.

The extent to which malnutrition rates affected households depends on their coping mechanisms (Rugamela, 1999; FAO, 2001). Moreover, the health sector is affected by an increased burden of caring for those infected with HIV. Health-care services face different levels of strain, depending on the number of people who seek services, the nature of the demands for health care, and the capacity to deliver that care. The 2001 Swaziland Human Development report estimated that people living with HIV/AIDS occupied half the beds in some health-care centres in that country. HIV prevalence among hospitalised patients was almost 33% in one Tanzania hospital, making HIV the most important cause leading to hospitalisation (UNAIDS, 2002). The World Bank estimates that the number of hospital beds needed for AIDS patients could exceed the total number of beds available in Swaziland by 2004 and in Namibia by 2005 (World Bank 2000). The pressure on the health facilities cannot be managed with the limited resources available to the countries with high prevalence rate. This is one of the reasons why Africans infected with HIV die much sooner after diagnosis than HIV-infected persons in the other parts of the world.

Gilks (1999) has explored the health related factors that affect the longevity of the life of HIV patients in Africa. The factors include, lower access to health care, poor quality of health care services, poor levels of baseline health and nutrition, and greater exposure to pathogens likely to result in opportunistic diseases and early death. Studies have also shown that HIV infection significantly reduces the fertility levels of HIV –positive women in the sub-Saharan African countries. Studies on fertility in 20 sub Saharan African countries found a 25% to 40% decline in fertility among HIV+ women compared with their counterparts who are HIV-negative (Gilks 1999, Gregson et al 1999).

2.6 THEORETICAL FRAME WORK

Behavioural change is hard to achieve at the best of times. It is harder to sustain where peoples' pleasure are involved. Since sex has been implicated as a major route of HIV transmission, many HIV/AIDS interventions have focused on changing sexual behaviours. Although it is true that people can modify their behaviour in relation to the way they engage in sex, sex itself is a physiological need. There are a lot of social theories and models that have tried to relate behavioural change with sexual behaviour with reference to reproductive health. Various theories and models that are relevant to the subject matter will be discussed in this section. The theoretical orientation of this work is focused on the following:

- The Theory of Reasoned Action
- The Health Belief Model (HBM)

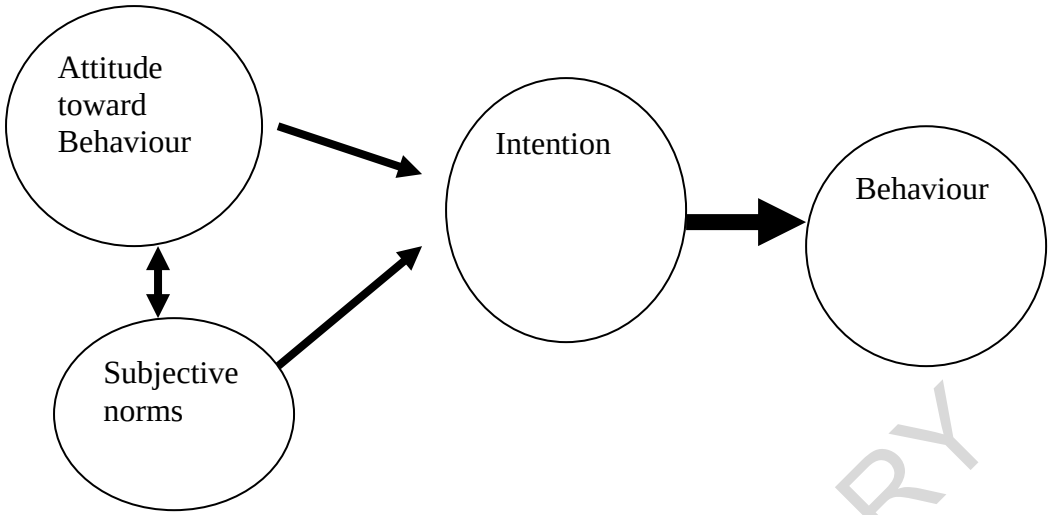
- Diffusion of Innovation Theory

2.6.1 THE THEORY OF REASONED ACTION

The theory of Reasoned Action specifies that there are two determinants of Behavioral Intention; the person's Attitude toward behaviour and his subjective norm related to the behavior (Fazio and Zanna, 1981).

According to the theory, the determinant of a person's behaviour is his intention to either perform or not to perform the specific behavior. For example, a man can decide whether to have extramarital affairs or not, know the implications (being infected with venereal diseases) especially without using condom. Due to the difficulties that are always privy to a person's intention, the theory of Reasoned Action specified two conceptually independent factors, that is, interacting together, and how they influence person's behaviour. (Fishbein & Ajzen, 1975; Ajzen & Madden, 1986).

Attitude according to the Theory of Reasoned Action, results from the information an individual has about the given object (Petty and Cacioppo, 1981). For instance, misconceptions regarding HIV\AIDS and other STDs can act as hindrance to behavioural change. So, an alternative way to assess a person's attitude would be to measure the available (or salient) beliefs that person has about that object.



Adapted from: Ajzen & Madden (1986). *Prediction of Goal-Directed Behavior: Attitudes, Intentions, and Perceived Behavioral control.*

These beliefs are combined and help to evaluate behaviour under consideration. In this case, it is important to note that it may occur that a person holds a large number of beliefs about a given object, but only a small number, about 5 to 9 of them, would serve as determinants of attitude (Fishbein and Ajzen, 1975). The belief of people and their attitudes towards premarital and extramarital affairs will go a long way in determining the rate of transmission of HIV/AIDS within the society. Other factors can also influence the spread of the disease depending on the importance attached to it by the people.

Subjective norm component of the theory deals with the influence the social environment may have on behaviour. Basically, the “Subjective Norm” refers to an individual's perception about his peers, family or friends opinions and how this perception influences him to whether or not perform a specific behavior. Findings have shown that peer group serves as reference point for assessment of primary sexual behaviour. For example, boys evaluate themselves and one another on aspects of masculinity such as growing pubic hairs. Girls discuss biological changes in their bodies like menstruation, breast development e.t.c which may have consequences on sexual behaviour (Odujinrin, 1991; Okonofua, 1992 Adeyemi, 1999).

However, the theory focused on inter-personal relationships, the intimate one-on-one relationships, without taking into account the institutions and environment in which these relationships were taking place. It also tended to assume to a greater or lesser degree that people were rational and logical, and that they had the resources, support and confidence to make the changes that were necessary in their lives. This approach tended to be individualistic, and ignored societal and cultural norms, as well as religious and gender constraints. It also ignored the complexity of sexuality and human behaviour and people's tendency to underplay the possibility that they are at risk.

2.6.2 THE HEALTH BELIEF MODEL (HBM)

The HBM is based on the understanding that a person will take a health-related action if he or she is faced with the following options:

- feels that a negative health condition (i.e., HIV) can be avoided by using condom,
- has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and
- believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).

The Health Belief Model is a framework for motivating people to take positive health actions that use the desire to avoid a negative health consequence as the prime motivation. For example, HIV is a negative health consequence, and the desire to avoid HIV can be used to motivate sexually active people into practicing safe sex (Resources Centre for Adolescent Pregnancy Prevention, 2004).

It is important to note that avoiding a negative health consequence is a key element of the HBM. For example, a person might continue to have sexual intercourse with the use of condom to avoid unwanted pregnancy. The Health Belief Model (HBM) stresses personal responsibility, which may lead people to feel it is their fault if they cannot solve their own health problems. Unfortunately, a health problem is often more complex or may be caused by factors over which an individual has less personal control (e.g., economic or environmental factors).

The HBM focuses on beliefs and attitudes and, as such, may be less appropriate for dealing with habitual behaviours like smoking, dieting, or other emotionally motivated health behaviours. These behaviours should be addressed separately. In addition, economic and environmental factors are not addressed with the Health Belief Model since these may be out of an individual's control (Cullinan, 2004).

HBM is Based on Six Key Concepts

Concept	Definition	Application
1. Perceived Susceptibility	One's belief of the chances of getting a condition (e.g. HIV/AIDS, STIs)	Define population(s) at risk and their risk levels Personalize risk based on a person's traits or behaviours Heighten perceived susceptibility if too low.
2. Perceived Severity	One's belief of how serious a condition and its consequences are	Specify and describe consequences of the risk and the condition
3. Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take — how, where, When Clarify the positive effects to be expected Describe evidence of effectiveness
4. Perceived Barriers	One's belief in the tangible and psychological costs of the advised behavior	Identify and reduce barriers through reassurance, incentives, and assistance
5. Cues to Action	Strategies to activate "readiness"	Provide how information Promote awareness

		provide reminders
6. Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance, and positive reinforcement

Adapted from: Theory at a Glance: A Guide for Health Promotion Practice (1997),

2.6.3 DIFFUSION OF INNOVATION THEORY (DIT)

Since individual theories fail to acknowledge societal norms , culture , gender and religion, infuse meaning into behaviour. diffusion of innovation theory was based on accepting that people's behaviour was influenced by the contexts in which they took place. It believes that a range of things collectively influence people's behaviour, including their families and neighborhoods, and identified that culture could have both positive and negative effects. DIT is based on getting community leaders to act as agents of change, and influence community members especially in relationship with HIV/AIDS stigmatization and discrimination. The community need to be educated on how to accept the PLWHA into the society and not to discriminate against them. It was also believed that by involving the community, norms and values will be incorporated and this will reduce the spread of the disease in our society.

In conclusion, from the above review, it is expedient that Health Belief Model is the best theory. The model is deserving of serious consideration in the context of this research because of its reliance on individual perceptions. It claims to have the capacity to explain many ways that different individuals go about maintaining their health.

The Health Belief Model relies primarily on the subjective interpretations and meanings that individuals assign to symptoms and illnesses. There are many variables that help form these perceptions. An individual's social and demographic background can have a dramatic influence on their perceptions. Prior knowledge or experience of a disease can also alter someone's perceptions. For those with chronic diseases like HIV/AIDS, there is often some sort of lay consultation that takes place before they resolve to take a recommended health action. Health Belief Model has been confined to preventive medicine. It is in these situations that the subjective interpretations that individuals assign to their illnesses have been readily observed. The perceptions that the model relies on are: the perceived susceptibility to a disease, the perceived seriousness of a disease, the perceived benefits of action, the perceived barriers to action, and the overall perceived threat of a disease. For those affected with HIV/AIDS these perceptions can influence whether or not they follow a prescribed health regimen.

2.7. CONCEPTUAL FRAMEWORK.

Recently, increased attention has been devoted to sexually transmitted infections (STIs), due to their growing importance over the past two decades. Throughout the world, and in particular due to the emergence of the new and very lethal infection agent, the Human Immunodeficiency Virus (HIV) which is the etiological agent of the Acquired Immune Deficiency Syndrome (AIDS), the review of relevant literature studies on HIV/AIDS has shown that several factors have influenced the spread of the virus. These variables are

incorporated in the conceptual framework (Figure 2) and the operational model in Figure 1. The operational model in Figure 1 shows that socio-demographic variables, will directly influence living with HIV/AIDS.

They will also influence the bio-medical factors, sexual behaviour\ networking, and susceptibility. Biomedical factors will directly influence living with HIV/AIDS. Sexual behaviour and socio-economic factors will have impact on living with HIV/AIDS and susceptibility to HIV. Lastly, living with HIV/AIDS will influence susceptibility and sexual behaviour. However, age at marriage is cited in literature as a major variable in HIV transmission. There are at least two reasons for this (i), lack of physical maturity and (ii) increased likelihood of seeking multiple partners. When girls marry at an early age, their bodies may not be fully developed (WHO, 1997) Young girls who marry older men may end up seeking sexual satisfaction and reproductive fertility elsewhere.

Cultural practices may both prevent and encourage the spread of HIV. In Ghana, students and teachers who participated in an HIV/AIDS Collaborative Learning Project on the prevention of HIV felt that puberty rites for girls promote abstinence and, therefore, prevent the spread of the epidemic. However, in some cultures, societal pressure upon women to be married by a certain age have contributed to unprotected sex and the spread of HIV/AIDS as young women seek to find a mate at almost any cost. In Zimbabwe, research findings show that traditional healers tell older men to have sexual intercourse with younger women in order to be cured of

HIV/AIDS. This may increase the vulnerability of the diseases and women may be infected (Population Reports, 2001). The highest rate of HIV infection in sub-Saharan Africa is among sexually active young women, less than 35 years old. Women in the age group 15-24 years old are more likely to be infected than men in the same age group, since women have their first sexual intercourse earlier than older sexual partners. The age at first intercourse will also affect the rate of infections.

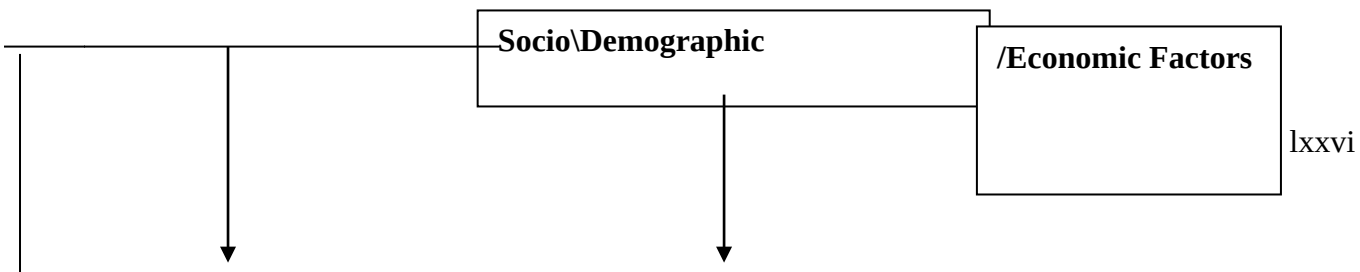
Education has been identified as an important variable influencing living with HIV and susceptibility such as multiple sexual partners and concurrent partners. Women‘s HIV risk increased with both her education and the male partner’s education. Studies have also shown that adolescents in school are more promiscuous than their counterparts who are not in school. Due to their level of promiscuity, there is increased risk of being infected with HIV. On the other hand, people with more education were far more likely to protect themselves by using condoms for casual sex. According to Population Report, (2001) an increase of even a few years of schooling translated into a rise in condom use, especially among girls. Marital status will also influence condom use, number of sexual partners, and presence of STIs. The AIDS epidemic varies with marital status.

Types of intercourse, use of condom, communication about sexual practices, will affect number of sexual partners, concurrent partner, or infection of STIs, which will in turn influence living with HIV/AIDS. Most of the available studies show that transmission of HIV

is mainly the result of multiple sexual partners in both heterosexual and homosexual relationships. Multiple sex partnership has a significant role in the volition of the HIV epidemic and it occurs in several forms; a person may have several sexual partners concurrently or one after another through divorce, separation, widowhood or inheritance. Higher wealth status exposes people to traveling, and more potential sex partners. It, however, also gives them more access to information and education about health hazard like HIV and puts them in a better position to look after themselves than the poor. The wealthy are able to look for and receive treatment in the case of any illness which, for STDs, is beneficial and will make the respondent less likely to acquire HIV. The individual can also afford to be selective about sexual partners and may not resort to prostitutes in the case of males, and high risk men like truck drivers, in the case of females.

The earlier people become sexually active, the more likely they are to change sexual partners and thus face a greater risk of exposure to STDs. Lack of information also limits women's ability to protect themselves from HIV. Studies have shown that AIDS is spread by migrant labour from the demand areas which are urban centres with prostitutes, to supply areas which are rural areas. This happens when the workers go back to visit families in holidays,

Figure 1: Operational Model Showing Factors Influencing the Spread of HIV/AIDS



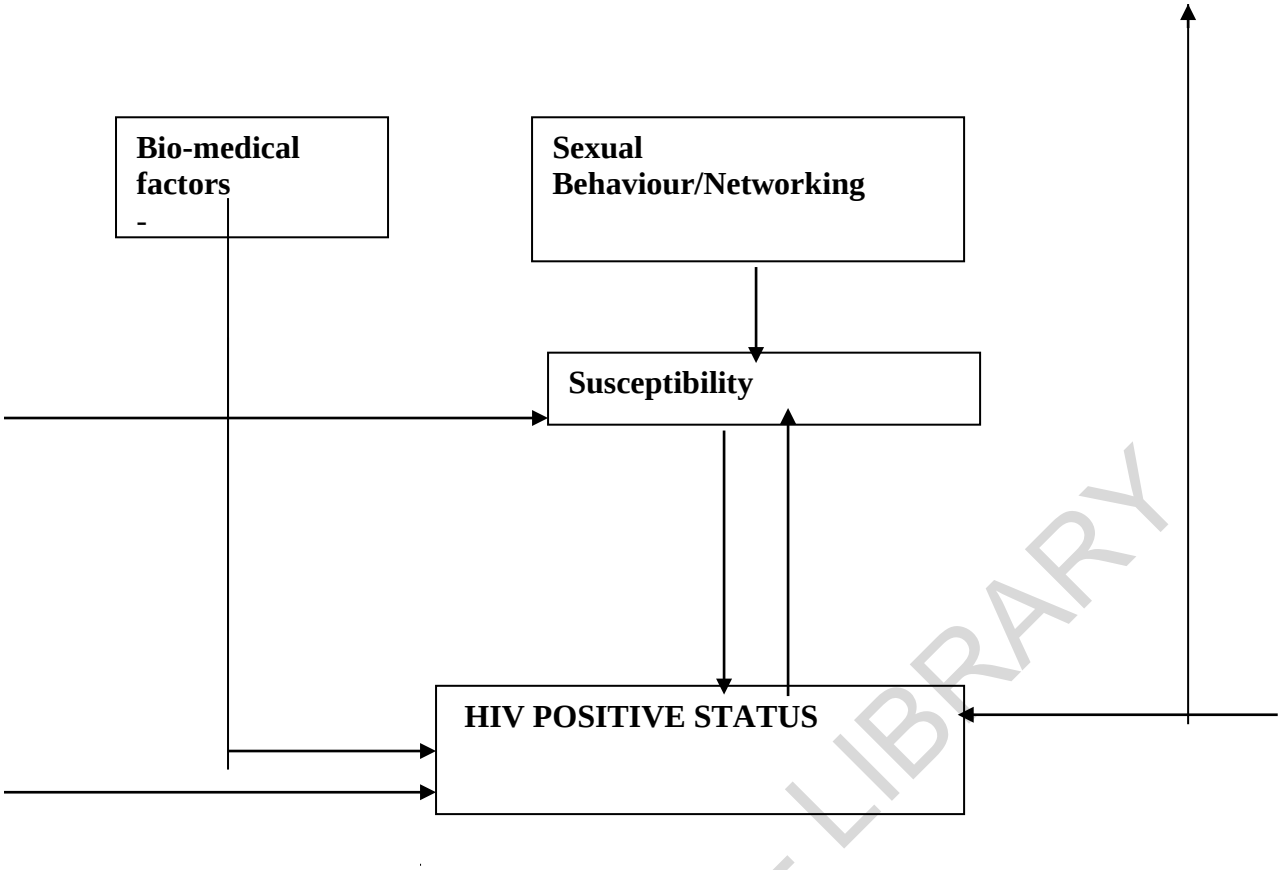
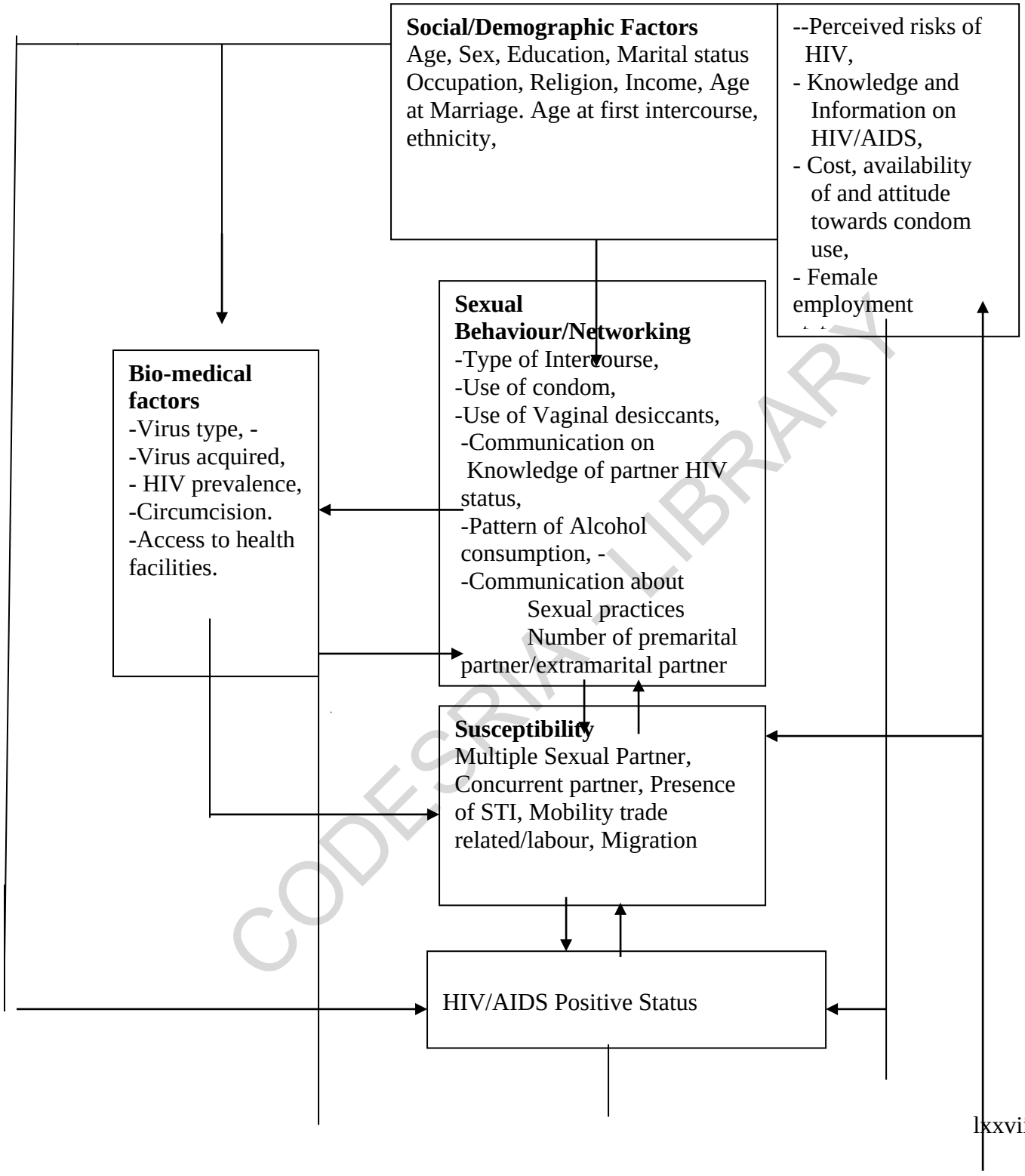


Fig 2. Conceptual Framework of Factors Affecting HIV/AIDS



SOCIO-ECONOMIC CONSEQUENCES
Psychological trauma, Loss of income, children drop-out from school, Increase in child labour increase in dependency, Discrimination and stigmatization, death of bread winner, burden on the health sector

weekends or ation on HIV/AIDS have been identified as part of factors influencing living with HIV/AIDS. Pattern of STD infection in communities are characterized by great heterogeneity in transmission rates within and between different populations. Access to medical facilities also influences the time of survival of people living with HIV/AIDS. Africans infected with HIV die much sooner after diagnosis than HIV-infected persons in other parts of the world. Studies conducted in industrialised countries prior to the introduction of treatment with multiple antiretroviral drugs, found that the survival time following the diagnosis of AIDS ranged from 6 to 26 months. In Africa, the survival time of patients with AIDS ranged from 5 to 9 months (UNAIDS, 1998).

From the conceptual framework, Figure 2, it is clear that socio-demographic variables, such as age, sex, age at first intercourse, income, occupation, religion, ethnicity/culture, perceived risks of HIV, knowledge and information on HIV/AIDS, female employment status, cost, availability of and attitudes towards condom use will influence living with HIV/AIDS and the intervening variables such as communication and knowledge about HIV/AIDS, condom use, number of sexual partners, and concurrent partners. The medical factors include, HIV prevalence rate, circumcision and access to health facilities that may directly influence living with HIV/AIDS. It will also determine the number of sexual partners, concurrent partners, and

premarital and extramarital partners. The operational model in figure 1 shows that living with HIV/AIDS is directly influenced by these variables.

Apart from the direct relationships, it was observed in the literature that sexual behaviour\networking would influence susceptibility, which in turn will influence living with HIV/AIDS. Factors such as types of intercourse, use of condom, use of virginal desiccants, communication about sexual practices and communication on knowledge of partners HIV status will influence multiple sexual partners, concurrent partners and presence of STIs. Susceptibility and vulnerability will influence rate of living with HIV/AIDS in any region or areas. Such factors include, multiple sexual partners, migration and presence of STIs. On the other hand, socio-economic consequences of living with HIV/AIDS will influence susceptibility and socio-economic factors.

2.8. HYPOTHESES

1. People living with HIV/AIDS are likely to spend more of their income on health care than those without HIV/AIDS.
2. Negative attitude towards people living with HIV/AIDS is positively related to denials of their HIV/AIDS status.
3. Sero-positive status of parents impact negatively on the education of their children.
4. Unwillingness to accept status reduces perceived risk of infection

and increases the spread of HIV/AIDS through multiple sexual partners.

5. Increase in the number of people living with HIV/AIDS is positively related to increase in the use of condoms

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 STUDY AREA

The study location is Lagos State. It is situated in the Southwestern part of Nigeria and lies approximately between Longitude 2^0 42^1E and $3^0 42^1$E, and latitudes $6^0 22^1$N and $6^0 52^1$N. The boundary area is defined by a 180 km- long Atlantic coastline in the south, the Republic of Benin in the west while the north and east boundaries are shared with Ogun state. (See figure 3). Lagos State is the smallest in size of the thirty-six States in Nigeria and has remained so since independence. This means that it is the only existing state in its form since creation. It occupies 3,577 square kilometres which represents only 0.4 percent of the entire area of the country (Odumosu, 1999).

Lagos State has a population of about 11,281,129, which represents over 6.2 percent of the national population of 130 million (2005 Population Projection Figure). At 9 percent per annum growth rate, approximately 300,000 persons per annum or 25,000 per month or 34 persons per hour are added to the existing population (Adedokun, 1999). This has resulted in very high population density of the state. The State has a density of 1,300 persons per square kilometres. Its population density is over 15 times of the national average which is 85 persons per square kilometres. Lagos State is the most urbanised State in the country (NPC 1991). The

domineering presence of Lagos metropolis as the former Federal Capital Territory (FCT), the commercial centre as well as its strategic location on the Atlantic coast, which other States cannot boast of, give some uniqueness to the State. The State is located within the wet equatorial climatic region which is characterised by high temperature, high humidity and heavy rainfall with double maxima. The State is situated in the forest region with thick vegetation, although this vegetation has given way, naturally, to developed land area except in the rural areas like Ibeju lekki, Ikorodu and Epe which dominate the major sources of forest products in the State.

This forest cover in the region produces reddish brown and loamy soil. The major agricultural activity in the State is fishing. This is due to the presence of the Lagoon, oceans and creeks in the State. The State has 20 Local Government Areas (see Table 1). It is the most heterogeneous state in the country. Apart from the major ethnic group, which is Yoruba, it houses virtually all known ethnic groups in the country with diverse social, economic, political and cultural characteristics. The original inhabitants of the State include the Ijebus who occupy the eastern part of the State from Somolu local government to Epe. The Aworis occupy the central part of the state from Lagos Island, Iddo Island eastward through Ojo Local Government to a part of Badagry. The third group, the Ogus occupy Badagry and its environs. There is a mixture of ethnic groups in the north central part of the state. There are the Aworis and Egbas in and around Ikeja, Agege and Alimosho (Odumosu, 1999).

The State remains the economic nerve centre of the country. It is the most industrialised state in the country and houses the headquarters of most companies, operating in the country, for example the headquarters of about 150 banks and several other financial institutions. The state has many educational institutions both private and public, including Polytechnics, two Colleges of Education and two Universities. Lagos State has the highest proportion of literate men and women in the country. Eighty percent of males (80%) and sixty-seven percent (67%) of females in the State have attended school at one time or the other. Eighty-three percent of the population of primary school age (6-11), 78% of secondary school age (12-17) and 29% of those of tertiary school age (18-23) are in school. Three major occupational groups in the city are traders, consisting 20%, white collar and other services 25%, production and transport 23% while farming and other primary activities constitute the rest (Noah 1997). The major religious groups in the State are Muslims, Christians and the traditionalists.

Table 3.1 Area of Lagos State by L.G.A and Population Density

L.G.A	1991	AREA (SQ. KM)	POPULATION
	POPULATION		PER SQUARE KM
AGEGE	651,1322	60	10,855
AJEROMI/IFELODUN**			
ALIMOSHO	430,890	137.8	3127
AMUWO-ODOFIN**			
APAPA***			
BADAGRY	119267	458	260
EPE	101464	995	102
ETI-OSA	175,700	222.71	789
IBEJU-LEKKI	24937	683	37
IFAKO-IJAYE*			
IKEJA	203383	49.92	4,074
IKORODU	184674	345	535
KOSOFE****			
LAGOS-ISLAND	165,996	9.26	17,926
LAGOS-MAINLAND	281,557	19.62	14,351
MUSHIN	539,783	14.05	38,419
OJO	1035221	375	2761
OSHODI/ISOLO	449781	41.98	10.714
SHOMOLU	771194	99	7790
SURULERE	586947	27.05	21810
TOTAL	5,725,116	3537.42	1,618

Source: Lagos State Lands Bureau, Survey Department, Ikeja
note: * ---- Data Contained in the Figure for Agege L.G
**-------Data Contained in the Figure for Ojo L.G
***-------Data Contained in the Figure for Eti-Osa LG
****------- Data Contained in the Figure for Shomolu LG

TABLE 3.2: DESIGNATION OF LOCAL GOVERNMENT AREAS: URBAN, SEMI-URBAN AND RURAL.

URBAN	PROJECTED POPULATION	SEMI-URBAN	PROJECTED POPULATION	RURAL	PROJECTED POPULATION
IKEJA	326512	ALIMOSHO	719586	EPE	162,891
LAGOS-ISLAND	266691	OJO	472886	IBEJU-LEKKI	40,034
LAGOS MAINLAND	432,777	BADAGRY	191,472		
MUSHIN	866,570	IFAKO-IJAYE	374631		
OSHODI/ISOLO	755081	IKORODU	296,476		
SOMOLU	566294	KOSOFE	671785		
SURULERE	742,122				
ETI-OSA	243362				
APAPA	262925				
AMUWO-ODOFIN	264227				
AJEROMI/IFELODUN	923836				
AGEGE	671004				

Note: The 2003 Projected Population was based on annual growth rate of 3.9448 percent supplied by the NPC.

Source: Central Office of Statistics, Ministry of Economic Planning and Budget 2001

Selection of Local Government Areas for the Study

The study was carried out in three Local Government areas in the State. Since the Local Government areas in the State have been grouped into urban, semi-urban and rural by the

National Population Commission in 1991, one Local Government was selected randomly from each of the subgroups (Ikeja, Badagry, and Epe. see Table 3. 2).

3.2 SAMPLE SIZE

In selecting the sample size for the general populace, EpiInfo Version 6 Statcalc software was used to determine the actual number of respondents to be interviewed. The software was designed to select sample size from a large population in social survey (Centre for Disease Control, 2000).

The following data were provided:

- The population of each local government (see Table .3)
- Expected frequency of the factor i.e. desired sample confidence interval (HIV/AIDS prevalence rate for the State 6.3%).
- Worst accepted result is the (HIV/AIDS National prevalence rate, 5.8%).

The equations of the EpiInfo Statcalc is

$S= Z*Z (P(1-P)/ (D*D)$

In which D is one half the width of the desired sample confidence interval. Z is a percentile of the standard normal distribution determined by the specified confidence level. It is 1.96 for 5% confidence level. S is then adjusted by a finite population correction factor to obtain the final estimate of sample size as, follows:

$Sample\ Size= S/(1 + S /population)$

From this information, EpiInfo Version 6 Statcalc determined the following sample sizes for each of the local governments.

Table 3.3 Summary Profile of Sample Size and Actual Number of Respondents

L.G.A'S SELECTED	POPULATION	SAMPLE SIZE	ACTUAL NOS OF RESPONDENTS INTERVIEWED		
		ENVISAGED	MALE	FEMALE	TOTAL
IKEJA	326,512	534	269	230	499
BADAGRY	191,472	472	250	201	451
EPE	162,891	415	212	196	408
TOTAL		1421	731	627	1358

3.3 SAMPLING DESIGN

PEOPLE LIVING WITH HIV/AIDS

Research in HIV infection is not like any ordinary phenomenon in demography, due to the stigma and discrimination attached to the disease . Even at the best of times, demographic data are affected by distortions and misinformation (Bleek 1981, 1987); AIDS is a disease whose sufferers have been stigmatised and blamed for the out break and the spread of the disease (Safo, 1993). Therefore, affected persons who agreed to be interviewed could be considered as those motivated enough to share their experiences with others (Awusabo-Asare, 2000). A related issue in AIDS research is ensuring confidentiality. Thus, in dealing with PLWHA patients, it is not possible to obtain a "representative sample" as is normally done in

population studies. Due to this, purposive sampling technique was used. People Livings with HIV/AIDS (PLWHA) were identified through the help of some organisations which are support groups that are dealing with them. These organisations were reached through the Family Health International (FHI) Lagos, an international (Non-Governmental) Organisation which is a donor to other organisations. The NGOs include:

1. Society for Women with AIDS in Africa, Nigeria (SWAAN), Apena Street, Surulere Lagos.
2. Stop AIDS, Race Course, Lagos.
3. AIDS Alliance of Nigeria, Igbosere Lagos.

The Academy for Educational Development. Agindingbi, Ikeja an international organisation was also contacted.

The consent of each of the interviewee was sought by filling a consent form (see appendix 4) before the interview. The researcher also employed the service of an HIV/AIDS counsellor who counselled each of the respondents interviewed. From these organisations, One–hundred and Eighty- eight PLWHA were interviewed based on this proportion:

1. Society for Women and AIDS in Africa = 78
2. Stop AIDS = 30
3. Academy for Educational Development = 50
4. AIDS Alliance Nigeria = 30

Total = 188

3.3.2 General Populace

The multi-stage random technique was used to select respondents from the general populace. This is to elicit information from the population about:

-Sexual behaviour and Networking

-Stigma and discrimination

-Effect of HIV/AIDS on the family.

-Change in sexual behaviour of people since HIV/AIDS pandemic.

However, to make the study representative of the whole population, three Local Governments were randomly selected from the listing of the twenty Local Government areas in the State (see Table 3.2). From these Local Governments, one Local Government was selected from urban, semi-urban and rural Local Government areas. These Local Governments have been divided into enumeration areas according to 1991 population census (NPC, 1991 see table 3.4). Fifty-four enumeration areas were randomly selected from Ikeja Local Government, forty-eight from Badagry Local Government and forty-two from Epe Local Government. From each of the enumeration areas, systematic random sampling was used to select five houses. Randomly, one household was selected from each of the selected houses. In each household selected,

lottery method was used to select a male or female in reproductive age 15-49 years that was interviewed. In all, 731 males and 627 females totaling 1358 respondents were interviewed on attitudes towards PLWHA and other health related matters.

Table 3.4: Selected Local Government and Their Enumeration Areas

SELECTED LOCAL GOVERNMENT	NUMBER OF ENUMERATION AREAS	POPULATION
IKEJA	510	326,512
BADAGRY	310	191,472
EPE	132	162,891

Source: National Population Commission 1991

3.3. 3 People Affected By AIDS (PABA)

Due to the nature of the research, Society for Women and AIDS in Africa and AIDS Alliance Nigeria were contacted to organise one FGD each for the people affected by AIDS. Since the disease was stigmatised and nobody will want to come-up openly that their relatives or friends are HIV/AIDS positive.

3.4 DATA COLLECTION

Triangulation method was used for the data collection. (Triangulation is referred to as the use of multiple sources and types of data in order to "validate' or give further support to the results from specific data sources). Both qualitative and quantitative methods were used for data

gathering. For quantitative data the Questionnaire method was used and for qualitative, Focus Group Discussion (FGD) and In-depth interview were used for the collection of data

3.4.1 Questionnaire:

Questionnaires are an inexpensive way to gather data from a potentially large number of respondents like the one at hand. Often, they are the only feasible way to reach a number of interviewee large enough to allow statistical analysis of the results. The questionnaire for the survey was designed to elicit information relating to the objectives of the study (see appendix 1). The questionnaire was divided into six sections including; background characteristics, sexual relations with partners other than spouses, STDs and health issues, AIDS awareness and knowledge, stigma and discrimination, attitudes towards people living with HIV/AIDS, attitudes toward cure for HIV/AIDS, care and support for living with HIV/AIDS.

Carefully selected and trained research assistants administered the questionnaires. The questionnaire was pre-tested with the objective of testing the adequacy of the tools and the ability of Research Assistants to administer them. The pre-testing lasted three days and the fieldwork was carried out for 30 days due to the nature of the research and the respondents.

3.4.2 In-depth Interview

Interviews are an important part of any social research as they provide the opportunity for the researcher to investigate further, and to gather data which could not have been obtained in other ways. In-depth interviewing, also known as unstructured interviewing, is a type of interview which researchers use to elicit information in order to achieve a holistic understanding of the interviewee's point of view or situation. It can also be used to explore interesting areas for further investigation. This type of interview involves asking informants open-ended questions, and probing, wherever necessary, to obtain data deemed useful to the researcher. As in-depth interviewing often involves qualitative data, it is also called qualitative interviewing (Glesne and Peshkin, 1992, Denzin and Lincoln, 1994). In-depth interview was employed to collect some qualitative data from the PLWHA. The in-depth interviews helped the researcher to know about their HIV/AIDS history, sexual attitudes about PLWA, economic consequences, stigma and discrimination, care and support. It allows person- to- person discussion. It also helped the researcher in getting insight into PLWHA's thoughts, feelings, and behaviour on HIV/AIDS (see appendix 2).

3.4.3 Focus Group Discussion (FGD)

Focus group discussion was conducted to supplement data collected from the questionnaire and in-depth interview. Focus groups discussion is a tool for collecting qualitative data from group discussions. It concentrates on words and observations to express reality and attempts to describe people in natural situations. The key element here is the involvement of people where their disclosures are encouraged in a nurturing environment (Denzin and Lincoln, 1994). It taps

into human tendencies where attitudes and perceptions are developed through interaction with other people. During a group discussion, individuals may shift due to the influence of other comments. Alternately, opinions may be held with certainty.

The purpose of using FGD for this survey is to elicit in-depth qualitative information about a group's perceptions, attitudes, and experiences on care and support for people living with HIV/AIDS. Two FGDs were conducted, one each for male and female, for people affected by HIV/AIDS. The researcher acted as a moderator, while an experienced note-taker was employed who took notes simultaneously as discussions were going on.

3.5 DATA PROCESSING

3.5.1 Qualitative.

The information collected from focus group discussions and In-depth interviews are raw data. The first step in processing them is that researcher transcribes the entire interviews verbatim. This would provide a complete record of the discussion and facilitates analysis of the data. The content of the discussion was analyzed and organized under different headings that depict different aspect of the discussions. The aim of this analysis is to look for trends and patterns that reappear within either a single focus group or among the focus groups or within the in-depth interviews. Kreuger (1988), suggests that content analysis begins with a comparison of the words used in the answer. Also, the researcher considered the emphasis or intensity of the

respondents' comments. This, information was analysed descriptively by using Alpha-Beta and Zy-index software and also to explain results of the qualitative data.

3.5.2 Quantitative (Questionnaire)

The administered questionnaires were edited and precoded by the researcher and data were entered into the computer by the data entry clerks employed for the purposes. The questionnaires were entered into computer using SPSS 11.0 Version for the analysis.

3.6 METHOD OF DATA ANALYSIS

The data collected from this survey was subjected to three levels of analysis. The first level involves an examination of the distribution of the respondents according to selected characteristics. This is because the behaviour of individuals in society is, to a large extent, determined by their personal characteristics as well as those of the environment in which they live. For this reason, it is expected that living with HIV/AIDS will be greatly determined by background characteristics such as education, age, marital status, type of marital union and sexual behaviours. To this end, simple percentages were employed to describe these variables. The second level involves the examination of the pattern of relationship between the dependent variables i.e. living with HIV/AIDS and other independent variables such as sexual behaviour, susceptibility, bio-medical factors, stigma and discrimination, effect on family members and friends.

The third level of the analysis involves the use of advanced statistical techniques to test the formulated hypotheses and the pattern of relationship between the dependent and independent variables. The regression technique was used to test these relationships. Specifically, logistics and ordinary least square regression were used to show the relationship between the dependent variable (e.g. ever used condom i.e. yes or no, having multiple partners, ever contracted STIs) and other independent variables (such as income, negative attitudes, age at first intercourse, perceived risk of infection, concurrent partner, STI, knowledge about HIV/AIDS), if the dependent variable is a dictomous one. Logistic regression is a sophisticated procedure that can be used successfully to test hypotheses like the ones outlined. It assesses relationships among variables or factors and has proficiency in detecting sources of variations and covariations. These apart, it is scientifically designed as an appropriate estimation model useful only when the dependent variable is dichotomous ranging between 0 and 1.

The logistics regression procedure estimates the probability that an event will occur for a dichotomous dependent variable.

The logit model is expressed:

Ln (P/1-P) =XQ + V……..i

Where:

V= the residual

Q= the coefficient

P= the probability of having sexual intercourse with partner apart from spouse

(1-P)= the probability of not having sexual intercourse with partner apart from spouse

LN(P/1-P) = the ratio of the probability of having sexual intercourse with partner apart from spouse to the probability of not sexual intercourse with partner apart from spouse

But since the independent variable (X) is more than one and of various categories, the equation will therefore be represented thus:

LN (P/1-P) = a + b1x1 + b2x2 + b3x3 +….. bnxn.

Where,

a = constant and,

X1….Xn… various categories of independent variables.

B1…bn are coefficients of various independent variables.

However, where the dependent variable is not dictomous Ordinary Least Square regression was used.

The qualitative data collected was transcribed and they were contents analyzed through the use of ZY-index software package for ethnographic data. The participants' responses were grouped according to similarities and dissimilarities in opinions. These responses were aggregated into a complex variable using Guttman Scale statistical analysis to test hypothesis about relationship among independent and dependent variables. This composite dependent variable has strong construct validity as well as ethnographic face validity because of the qualitative procedures that identify the individual behavioural items (Silva et al 1997).

3.7 Variables Analysed

In this study, the dependent variables are use of condom, having multiple sexual partners, ever contracted STIs, ever disclosing positive status. Some of them have two categories: (1) YES (2) No. This basically, will require quantum responses and thus are categorized as dichotomous variables.

The explanatory variables that were used in the analysis are variables that have been identified as relevant to the study. These were grouped into:

-Socio-economic characteristics	educational attainment, age, occupation, religious affiliation, rural/urban residency, housing unit etc
-Sexual behaviour and networking	number of sexual partners, duration of relationship and frequency of contraceptive use.
Sexually transmitted diseases	ever-contracted STDs, Types of STIs heard of, Sources of information, seek treatment for the cure of the disease
Perceived risks of HIV	Knowledge and information on HIV/AIDS
Stigmatization and discrimination	
Care and support for PLWA	
Economic consequences	loss of income, cost of treatment, child labour, and drop-out from school

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CHAPTER FOUR

SOCIO-ECONOMIC CHARACTRISTICS OF RESPONDENTS

4.1. Introduction

Background characteristics of the respondents are very important in the analysis of social survey related to human behaviour. In this particular study they help in understanding the impact of HIV/AIDS in the study area. This chapter is devoted to the discussion of the respondents' characteristics, which are considered important in this study. These variables include age, sex, marital status, educational level, ethnicity, religion, occupation, income, age at first marriage, age at first intercourse, knowledge and attitudes about HIV/AIDS, perceived risks of HIV/AIDS and cost and availability of condoms

4.2 PLACE OF RESIDENCE

Place of residence plays a paramount role in the formation of beliefs, values, attitudes and behaviour patterns, which eventually determine a person's perceptions and general outlook to life. It also determines access to health institutions. An individual's behaviour can be influenced by place of residence. HIV/AIDS is more predominant in the urban centres, since multiple sex is more pronounced in urban centres owing to their heterogeneous nature and they also promote commercial sex due to the proliferation of brothel and hotels in the study area. Place of residence is categorized into Urban, Semi-urban and Rural residence. From table 4.1, male respondents from the rural areas have the lowest figure (28.6%). The reason for this was that some men are working in Lagos while their families are at Epe, a distance of about 30

kilometers from Lagos. They normally go home during weekends and at times at night. This may be one of the reasons while HIV/AIDS prevalence is high in Epe compared with other rural areas within the State. Majority of the female population in the study area are in urban centre. This may be unconnected with the fact that those in the rural area might have gone for their daily trading activities, in the most popular fish market in the state. (Ebute market).

Table 4.1 Percentage Distribution of Respondents' by Sex and Place of Residence

	MALE (N= 731)	**FEMALE (N= 627)**	**TOTAL (N=1358)**
Place Of Residence			
Urban	37.5	35.9	36.7
Semi-Urban	33.9	32.6	33.3
Rural	28.6	31.5	30.0
Total	100	100	100

Source: Author's field survey, 2005

4.3 Age Composition of the Respondents

In any demographic analysis, age appears is one of the most important variables. It represents number of years lived by an individual from birth, and to a large extent the experiences and performances of an individual depend on this variable. It affects experiences and exposures to sex. A 10-year age grouping was used. The age patterns of the respondents indicated that two-fifth of the respondents (both male and female) are between ages 25-34 years. The proportion

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of respondents in age groups 15-24 years and 35-44 years are small for male and female respondents respectively. The pattern shows that the proportion of respondents in the younger age group is substantially larger than the proportion in the other age groups. This indicates that majority of the sample population are in the economically active group. It is also a true picture of population with high fertility (NDHS, 2003). They are the groups mostly affected with HIV/AIDS because of their pattern of sexual behaviour (Orubuloye, 1999).

Table 4.2 Percentage Distribution of Respondents by Age and Sex

	MALE (N= 731)	**FEMALE (N= 627)**	**TOTAL (N= 1358)**
AGE			
15-24 Years	10.0	22.3	15.7
25-34 Years	35.4	55.6	44.7
35-44 Years	19.4	1.1	11
45 & above	35.2	20.9	28.6
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

4.3. Marital Status of Respondents

Generally, marital status has demographic, economic, socio-cultural and health implications. The universality of marriage derives from the importance attached to the institution as the main social arrangement within which cohabitation and childbearing are approved. The analysis of data on marital status is of demographic importance since it illuminates the socio-demographic setting of reproductive activities (NPC, 1998). Marriage appears to be universal among both males and female; marital status of the respondents revealed that half of the male respondents are married, while only 38 percent of the females respondents are married. More females

indicated that they are divorcees (21.9 percent) compared with only 7.7 percent for males, 21.2 percent of females are widows. This observation reflects the effect of polygyny widely practiced in many parts of the country and differences in ages at marriage between spouses.

Table 4.3 Percentage Distribution of Respondents by Marital Status and Sex

	MALE (N= 731)	FEMALE (N= 627)	TOTAL (N=1358)
Marital Status			
Single	36.9	18.8	28.3
Married	55.4	38.1	47.5
Divorced	7.7	21.9	14.2
Widow/Widower	-	21.2	-
Total	100.0	100.0	100.0
Husband having other wives			
Yes	-	41.3	-
No	-	58.7	-
Total	-	100.0	-

Source: Author's field survey, 2005

Types of marriage have implications for the frequency of exposure to sexual activity and fertility. Forty-one percent of the female respondents reported that their husband have other wives, while 58.7% reported monogamous unions. Although previous studies have shown that polygyny is more prevalent among the rural women (NDHS 2003) but it is the same rate in this survey. The reason for the different pattern observed may be the impact of the urbanization and modernization in the study area. Studies have shown that types of marriages and cultural practices are among the factors influencing the spread of HIV/AIDS in sub-Saharan Africa. Polygyny has been identified as one the cultural practices that can lead to transmission of

sexually transmitted infections. Caldwell et al, (1999) in their study of sexual networking and HIV/AIDS in West Africa found that women who are in polygynous marriages have more extramarital sexual partners, compared with those in monogamous union, particularly women who receive little assistance from their husbands. Under such conditions other wives of the husband are also at risk of contracting STIs and HIV/AIDS

4.4 Age At First Intercourse

Age at first intercourse is used as a proxy for the outset of respondents' exposure to sexually transmitted diseases. Approximately two-fifths of females reported that they have their first sexual experience between age 15-19 years compared with one-third for male respondents. First sexual experience decreases with age for female respondents. By age 24 years more than 70% female respondents have had their first sexual experience. This is one of the reasons why HIV/AIDS prevalence is high among young married women compared with men of the same age group.

Table 4.4 Percentage distribution of respondents by Age at First Intercourse and by Sex

	MALE (N= 731)	**FEMALE (N = 627)**
Age at intercourse		
15-19	34.9	44.6
20-24	45.1	31.4
25 & above	20	24.0
Total	100.0	100.0

Source: Author's field survey, 2005

4.5 Educational Attainment of Respondents

Education is one of the basic indices of human development. It is the transformation of knowledge, skills, values, attitudes and norms of a society to the individual to enable him/her take up responsible roles in the society in which he/she lives. Educational attainment is the highest grade completed within the most advanced level attended in the educational system of the country where the education was received. People with formal education are more likely to have access to health information on the dangers of HIV/AIDS infections and to have knowledge of protective measures against HIV infection. The educational categories evaluated are Non- education, primary, secondary, post secondary (non degree) and post secondary (degree). Table 4.5 shows that 91 percent of the female population and 81.5 percent of male respondents had received formal education. Females with no education and primary education are more in number than male respondents. However, males were seen to have attained higher levels of education than females (25.4 percent with post secondary education among females as against 37 percent among males). This survey confirms earlier studies which propounded out that, there is a high level of literacy level among respondents in the South Western Nigeria. The introduction of free primary education in 1955 might have been responsible for the higher level of literacy (Ebigbola and Omideyi, 1988) It may be due to the impact of Unity Party of Nigeria's (UPN) 1979/83 free education programme in the western part of the country.

Finally the fact that the study area is more urbanized compared with other areas in the country cannot be ruled out. It can be deduced from Table 4.5 that the education of the respondents appears to follow the general pattern in the South Western Nigeria, where more males go to school and have relatively higher education compared to females

Table 4.5 Percentage Distribution of Respondents by Educational Status and by Sex

	MALE (N= 731)	**FEMALE (N = 627)**	**TOTAL (N =1358)**
Education			
None	18.5	19.3	21.1
Primary	15.0	28.1	26.2
Secondary	29.3	26.8	20.9
Tertiary	37.2	25.4	31.8
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

4.6 RELIGION AFFILIATION OF RESPONDENTS

Religion can be described as the beliefs and practices associated with the supernatural. It influences the behaviour of individuals through faith or belief in a supernatural being by adherence to "divine" laws and commandments. All the three major religions in Nigeria restrict coital intercourse within the frame of marriage. Some religions endorse polygyny, while others do not. For example, Islamic and Traditional religions allow polygyny, but Christianity preaches monogamy.

Religious affiliation has the tendency to influence transmission of HIV and reproductive behaviour. Religiosity is often positively associated with social values and behaviour, and

negatively related to premature sexual involvement and delinquency (Jeremiah, 1997). Religion has a profound impact on individual behaviour; even in the face of modernization and its consequences on cultural practices. Indeed, religion seems to hold a firm grip on the moral values relating to sex and sexuality (Adepoju and Ogunjuyigbe, 2004).

The distribution of the respondents by religion shows that three out of every five respondents are Christians; while only 1.9 percent of the respondents indicated that they were traditional worshipers. The proportions of female respondents who are Muslims are greater than their counterparts who are Christians. The reason for this result may be due to the proliferation of churches and mosques in the State, with the impact of urbanization and modernization, which have eroded cultural values and beliefs in the area.

4.6 Percentage Distribution of Respondents By Religion and Sex

	MALE (N= 731)	**FEMALE (N= 627)**	**TOTAL (N =1358)**
Religion			
Christianity	69.6	49.1	60.2
Islam	29.1	48.2	37.9
Traditional	0.2	2.7	1.9
Total	100	100	100

Source: Author's field survey, 2005

4.7 INCOME DISTRIBUTION OF THE RESPONDENTS

Income is an important variable that influences sexual behaviour. Studies have shown that income influences female ability to say no to sex and the use of contraceptives (Orubuloye et al 1993, Ogunjuyigbe and Adeyemi, 2005).

From table 4.7, 74% of the respondents earn less than N120, 000 per annum. This shows that majority of the respondents are poor, going by the UN standard of earning $1 per day. Two-thirds of the female populations are within this range while less than 5% of them earn above N360, 000 per annum. This also supports previous findings. Adepoju (2004) for example explained that women are now the poorest of the poor. Often, young girls-mothers of tomorrow –are withdrawn from school because their parents choose only to educate their brothers with the diminished household income. Young girls may also be withdrawn from school because the family requires their labour to help their mothers and aunts, in the face of dwindling family labour pool and expensive hired labour. However, information on income should be handled with caution because of the high degree of unreliability.

4.7 Percentage distribution of respondents Income Status by Sex

	MALE (N= 731)	**FEMALE (N= 627)**	**TOTAL (N= 1358)**
Income per Annum			
< N120,000	55.8	63.0	74.0
N121,000-N240,000	18.5	21.5	11.8
N241- 360,000	12.9	10.6	9.2
N361,00 & above	12.9	4.8	5.0
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

4.8 OCCUPATION OF RESPONDENTS

Occupation, like education, is also a source of empowerment for women, especially if it puts them in control of income. Table 4.8 shows that more than half of the respondents are employed in trading services, regardless of sexes. A higher proportion of females compared to male respondents (21.5% and 18.5% respectively) are in civil /public service. Twelve percent of male respondents are professionals compared with female respondents, which are less than five percent. This reveals gender gap in education in Nigeria, where more males are in professional courses in the higher institutions than their female counterparts. Eight percent of the female respondents are full-time house wives who depend on their husbands for survival. Such women may not be able to take reproductive decisions without the consent of the husbands.

4.8 Percentage Distribution of Respondents By Occupation and By Sex

	MALE (N= 731)	**FEMALE (N= 627)**	**TOTAL (N= 1358)**
Occupation			
None	-	8.0	3.7
Trading	55.8	55.0	55.4
Public\Civil Servant	18.5	21.5	19.9
Artisans	12.9	10.6	11.8
Professionals	12.9	4.8	9.2
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

4.9 ETHNICITY

Nigeria is a multi-ethnic state with about 350 ethnic groups (Ottite, 1979). This ethnic variety is found in towns and cities in Nigeria. Ethnicity is an important variable in the study of demographic characteristics of a population. All over the world, ethnic groups have varied cultural norms, values, beliefs and practices which influence sexual and reproductive behaviour. A person's cultural background can have a strong influence on his or her sexual attitudes and behaviours, sexual mixing patterns, and choices of partner. Documentation from the analysis of various ethnic groups in Nigeria and around the world shows that ethnic groups exhibit unique characteristics in terms of education, age at marriage, age at first intercourse, sexual behaviour which directly or indirectly affects HIV/AIDS transmission. It has influence on mortality, as some cultural practices tend to have negative influence on the health of people. This often predisposes people to the risk of death. For example the female genital cutting and sexual rites in some countries lead to increase in HIV/AIDS transmission and infections (Coleman and Charles 2001).

In this study the various ethnic groups have been classified into four; Yoruba, Ibo, Hausa/Fulani, and others. Table 4.9 shows that Yorubas predominate in the study and the reasons for this is that the survey was carried out in Yoruba speaking communities. Other ethnic groups residing in the study area are Ibo, Hausa/Fulani and other minority groups.

4.9 Percentage Distribution of Respondents By Ethnicity and By Sex

	MALE	FEMALE	TOTAL

	(N= 731)	(N= 627)	(N= 1358)
ETHNICITY			
Yoruba	44.6	75.4	57.7
Ibo	26.1	24.4	25.4
Hausa/Fulani	10.8	0.2	6.3
Others	18.5	-	10.6
Total	100	100	100

4.10 Percentage Distribution of Rooms Used by Respondents

The number of rooms a household used for sleeping gives an estimate of the extent of crowding. It is also an indicator of socio-economic status. The survey collected data on the number of rooms used by households in the study area. Table 4.10 shows that about half of the respondents use only one room for sleeping. More females than males indicated that they used one rooms for sleeping. Only 18.5 % and 3.1 % of males and females respectively are using self-contained apartment of two or three-bed rooms. The result revealed the real situation of the study area about the extent of over crowding and congestion in Lagos State. Average number of people sleeping in a room is five, which is high compared with other towns and cities in Nigeria. This depicts slums in the area which has implications for HIV/AIDS infections. UNDP (2001), explained that the impact of slums on the spread of HIV/AIDS is immense. Poverty, illiteracy, political and social repression, exploitation, crime, unemployment; drive people towards taking drugs. They also aggravate the vulnerability of women, in particular, to the HIV infection.

In an environment of overcrowding, violence, crime, alcohol consumption, rape and sexual exploitation are prevalent. Women are therefore at risk of getting HIV because they do not have the status or economic and social empowerment to negotiate safe sex. Many are compelled take to commercial sex. Illiteracy and overall lack of awareness about health, especially reproductive health, make women highly susceptible to sexual exploitation and violence. Concurrently, slums do not provide the necessary healthcare infrastructure where women can seek advice for reproductive health problems be it birth control, abortion, safe delivery or treatment for STD and HIV.

Table 4.10. Percentage Distribution of Rooms Used by Respondents

No of Rooms	**MALE (N= 732)**	**FEMALE (N = 627)**	**TOTAL (N=1358)**
One-Room	47.3	57.9	52.0
Two-Rooms	34.2	39.0	36.3
2 or 3 bedrooms	18.5	3.1	11.7
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

4.11 KNOWLEDGE ABOUT HIV/AIDS

Since HIV/AIDS was first discovered in Nigeria in 1986, numerous programmes have been undertaken by government and Non-Governmental Organizations (NGOs) to inform the general population about HIV and other sexually transmitted diseases. Such programmes aim at increasing the knowledge about HIV/AIDS, decrease risky sexual behaviours and influence attitude to people living with HIV/AIDS. It is expected that increased level of accurate

knowledge about how to avoid infection are likely to reduce the number of new infections, since the control of the disease depends among other things, on the perception of the risk and change of reproductive behaviour. From table 4.11, 95% of the respondents were aware about HIV/AIDS. The high knowledge of the disease in the study area is due to the literacy level of the respondents with the public awareness about the disease. People with formal education are more likely to have access to health education, which makes them to be aware of the dangers of HIV/AIDS infections and to have knowledge of protective measures against HIV infections.

More males (95.0%) indicated that they have heard about the disease than female respondents (92%). The difference may be due to the gender disparity in the discussion of sexually related matters and access to media. In relation to the place of residence, thirty –seven percent of urban respondents, 28% of rural men and 31% percent of rural women had heard of AIDS. As expected, this knowledge is slightly higher in urban areas, where there is access to media, than in rural areas. Another factor is that urban areas have higher levels of infections and consequently, deaths which could make more people aware of the epidemic. This was also in line with the responses from People Affected by AIDS about what they understand about HIV/AIDS.

A male student

HIV is an epidemic that has confronted the whole world and has resulted in the death of many people.

An apprentice:

HIV leads to the disease called AIDS. It is a virus and when it gets into the body system, it destroys the immune system. When the immune system is compromised, the soldiers in the body will not be able to cope with it. When it is not managed properly it turns to AIDS

A female respondent:

HIV is a virus, while AIDS is the disease.

An Illiterate woman

It is a disease that when you are infected you will start to loose weight and other symptoms like fever, diarrhea, sore will be showing in your body (Translated from Yoruba language) .

With all these responses, it shows that majority of the respondents knew about the virus and the deadly disease in the study area. It also revealed that they also know some of the symptoms of the disease.

4.12 SOURCES OF INFORMATION

The mass media, especially television and radio reach large numbers of young people around the world and have enormous influence. In virtually all developing countries most females aged 15-19 years have regular access to television and radio, while young people obtain a great deal of information about reproductive health from entertainment programmes in the mass media (UNFPA, 2001). Majority of the respondents mentioned radio as their main source of

information about HIV/AIDS. This is the major source of information in both rural and urban centres. Nearly every household could afford small transistor radios, which run on cheap batteries. More female respondents indicated that television is the source of their information and this confirms the previous findings that women have more access to television than men (UNFPA 2001). This may be due to the fact that women stay more at home when taking care of the children. Surprisingly, females that indicated newspaper as their sources of information are higher than males. This may not be unconnected with the proliferation of various newspapers in the study area in the indigenous language.

4.13 MODE OF TRANSMISSION

Knowledge about mode of transmission is important in the prevention of HIV/AIDS. As shown in table 4.5 four out of every five respondents knew that people can be infected through multiple sexual partners. More females (95.2%) than males (74.96%) mentioned blood transfusion than male respondents. Other modes of transmission mentioned are, pedicure and manicure (males 62.5%, females 62.3%) unsterilised needles (males 74.28%, females 84.22%), having sex with prostitutes (males 89.06%, females 95.8%) and mother- to-child transmission (males 37.3%, females 59.2%). These show that the respondents have good knowledge of the mode of transmission of the disease. UNICEF (2001), revealed that the mode of transmission of HIV in Nigeria can be classified into three principal categories: sexual route, mother to child transmission and unsterilised instruments, which in turn can be sub-divided into transmission through contaminated blood and through the use of contaminated instruments. This shows that

there is no misconception about the mode of transmission of the HIV virus among the study population. This can also be supported by the responses from the in-depth interviews and focus group discussion conducted among people living with HIV/AIDS as well as people affected with AIDS

A male discussant expressed the mode of transmission thus,

HIV/AIDS can be contracted through multiple sexual partners, use of unsterilised needles and through blood transfusion.

A 35 year-old male who is HIV positive says,

I can say from my own experience that I contacted the disease through my illicit sexual act. I have many sexual partners and always practice unprotected sex. I know that is where I contacted the disease and this is an important mode of transmission

A 29 year- old woman who is HIV positive:

Many women who are faithful including their partners can contact the disease through unscreened blood. My case is an example of one of such women.

TABLE 4.11 PERCENTAGE DISTRIBUTION OF RESPONDENTS BY AWARENESS OF HIV/AIDS

Heard of HIV/AIDS	MALE	FEMALE	TOTAL
Yes	95.0(731)	92.0 (627)	94.0(1358)
****Place of Residence**			
Urban	37.5(262)	35.9 (202)	36.9 (462)
Semi-Urban	33.9(236)	32.4 (181)	33.3 (417)
Rural	28.6(197)	31.7 (177)	29.8(374)

Total	100.0	100.0	100.0
****Sources**			
Radio	63.0(461)	36.0 (219)	50.8(680)
TV	18.5(135)	44.6 (271)	30.3 (406)
Newspaper\Magazines	18.5(135)	19.4 (118)	18.9(253)
Total	100(731)	100 (608)	100 (1339)
* Mode of Transmission			
Multiple Sexual partner	82.07(600)	94 (589)	88.0 (1189)
Unsterilized needle	74.28(543)	84.22 (523)	78.49 (1066)
Pedicure/manicure	62.5(456)	62.3 (387)	62.0 (843)
Sharing of Blades/needles	47.19(345)	52.0 (326)	49.4 (671)
Blood transfusion	74.96(548)	95.2 (597)	84.3 (1145)
Sex with Prostitute	89.05(651)	95.8 (601)	92.2 (1252)
Mothers- to- Child	33.51(245)	55.02(345)	43.4 (590)

Source: Author's field survey, 2005. ** Excluding Non Response Category
* Multiple Responses are allowed.

4.14 Voluntary Counseling and Testing (VCT)

Voluntary counseling and testing for HIV is a necessary precursor to developing effective treatment, care and support services including programmes to reduce mother-to child transmission, preventive therapy for tuberculosis, or the administration of antiretroviral therapies. Voluntary counseling testing may also reduce reported risk behaviour and prevent new infections –notably among those tested positive and among discordant couples (Kamenga *et al* 1991, Allen *et al* 1992, Weinhardt *et al* 1999).

Respondents were asked about their HIV/AIDS status, one-quarter of the male and less than 5 percent of the female respondents respectively being negative, while others didn't know their HIV/AIDS status (Table 4.12). Only half of the respondents were willing to do HIV/AIDS test. Majority of the respondents do not want to do the test. When asked the reason why they

are declining to take the test, majority of the respondents (80.2%) indicated that they were afraid of the possible outcomes. They believed as some participants in the FGD sessions indicated that "it is better not to know about the status and continue normal life than go for the test and start to die gradually before the real death". Few respondents (9.9%) believed that "they can not have the disease based on their faith in God". This is also supported by the focus group discussion among the people affected by AIDS.

A male discussant expressed his opinion:

Most people don't want to go for the HIV/AIDS test because of the fear of being positive. They have the belief that it is better not to know the status than dying gradually before the real death"

A female discussant:

Some people believe that they cannot contact the disease because of their faith in God. Even when they are involved in risky behaviour.

There are misconceptions about the HIV/AIDS. Some of the respondents also have the misconception that "they cannot be infected since they do not practise unprotected sex". They perceived that they are not at risk of getting the virus, forgetting that unprotected sex is not the only mode of transmission of the disease. This shows that the respondents' lack the understanding of risk of infection.

Two out of every five respondents of the sampled population believed that if they tested positive, they would transmit the disease. More male respondents indicated that they will transmit the infection. This can lead to increase in the prevalence rate of the disease in the study area. On what the respondents will do if their partners tested positive, more than 50

percent of males indicated that they would abandon her, while about 20 percent of the female respondents indicated that they would abandon their husbands. This shows that women have more compassion for their husbands than the other way round. The reason for these differences is that men believe that they can marry another wife, while it will be difficult for the woman to remarry because of the stigma attached to it in the society. This finding is also in conformity with the previous findings that women are normally abandoned or sent away when they are confirmed positive (UNFPA,1999)

Table 4.12 Percentage Distribution of Respondents By Voluntary Counseling and Testing (VCT) and by Sex

VARIABLES	MALE	FEMALE	TOTAL
HIV Status			
Positive	-	-	-
Negative	26.1 (191)	0.5 (6)	14.3 (194)
Don't Know	73.9 (540)	99.5 (621)	85.7 (1164)
Total	100.0 (731)	100.0 (627)	100.0 (1358)
Willing to do HIV/AIDS Test			
Yes	49.9 (361)	58.2 (354)	52.7 (715)
No	50.1 (370)	41.8 (273)	47.3 (643)
Total	100 (731)	100 (627)	100.0(1358)
If No Why?			

Afraid of Possible Result	100 (370)	47.2 (153)	80.2 (523)
Religion	-	52.8 (134)	19.8 (134)
If you tested positive What will you do			
Treat myself	18.5 (135)	22.0 (138)	20.1 (273)
Transmit it	44.6 (326)	56.3 (353)	50.0 (679)
Kill myself	36.9 (270)	21.7 (136)	29.9 (406)
Total	100.0 (731)	100.0 (627)	100.0 (1358)
If your partner is tested positive			
Abandon him/her	55.4 (405)	19.0 (119)	38.6 (524)
Treat him	26.1 (191)	54.8 (344)	39.4 (535)
I don't know	18.5 (135)	26.2 (164)	22.0 (535)
Total	100.0 (731)	100.0 (627)	100.0 (1358)

Source: Author's field survey, 2005

4.15 AWARENESS ABOUT PEOPLE LIVING WITH HIV/AIDS

Information about people living with HIV/AIDS and deaths associated with AIDS may modify behaviour. From Table 4.13, eighty percent of the respondents are aware of the increase in the number of people living with HIV/AIDS. More females (3.2%) knew someone living with HIV/AIDS than males (1.6%). Since women normally visit hospital for ante-natal and post-natal clinics, there is tendency for them to meet some of their cohorts who are infected. Also there is tendency for people living with HIV/AIDS to confide in women than men. As the epidemic matures and mortality increases, one would expect an increase in the proportion of respondents who knew someone who died of AIDS. However less than five percent of sampled population indicated that they knew a person who died of AIDS.

The unwillingness of affected persons to reveal their identity is due to the stigma attached to HIV/AIDS. This position was confirmed in the focus group discussions among people affected by AIDS (PABA). Most of the discussants agreed that those affected do not disclose their status and their families also do not tell others the cause of their death when they eventually died. Ashton and Ramasar (2002), in their study, revealed that due pervasive and wide spread sense of "shame' associated with HIV/AIDS sufferers, family members are very reluctant to admit to relatives, friends and colleagues that one or more members of the family are HIV-positive. They explained that in the past the situation has been aggravated by the violent reactions of friends and neighbours to the news that one of their friends or colleagues has HIV/AIDS or has died as a direct or indirect result of HIV/AIDS. Another reason why the epidemic is not taken more seriously is that people cannot identify the disease with specific deaths. Newspaper occasionally publishes statistics but not the fact that fellow townsmen or well-known persons have died of the disease

4.13 Distribution of Respondents by Awareness About People Living With HIV/AIDS

Heard of increasing Number of PLWHA	**MALE**	**FEMALE**	**TOTAL**
Yes	92.3 (675)	44.0 (276)	70.0 (951)
No	-	18.8 (118)	8.7 (118)
Don't Know	7.7 (56)	37.2 (233)	21.3 (289)
Total	100 (731)	100.0 (627)	100.0 (1358)
Have Friends /Relatives with HIV/AIDS			
Yes	1.6 (12)	3.1 (20)	2.4 (32)
No	98.4 (719)	96.9 (607)	97.6 (21)
Total	100.0 (731)	100.0 (627)	100 (1326)
Friends /Relatives died of			

HIV/AIDS			
Yes	91.7 (11)	50.0 (10)	65.6 (21)
No	8.3 (1)	50.0 (10)	34.4 (11)
Total	100 (12)	100 (20)	100 (32)

Source: Author's field survey, 2005

4.16 COST AND AVAILABILITY OF CONDOMS

Condoms are an effective, inexpensive form of birth control. Unlike many other forms of birth controls, condoms also offer effective protection against most serious sexually transmitted infections by preventing the exchange of body fluids, such as semen, genital discharge, or infectious secretion, which are the primary routes of transmission of STDs. Additional advantages of condoms are low cost, easy access, simple disposal, minimal side effect, and longer –lasting sex play. Using condoms can also enhance sexual pleasure by reducing anxieties about the risk of infection and pregnancy (Warner and Hatcher, 1998).

Annually, an estimated 6 billion condoms are distributed which is far short of current need, and the need is growing rapidly (UNFPA, 2001). Since the availability of condoms will affect the spread of sexually transmitted disease and HIV/AIDS in particular, information on the availability and cost of obtaining a packet of condom were requested from the respondents. From Table 4.14 majority of female respondents (74.8%) do not know the cost of the packet of a condom, while the prices of a packet range from N20 to N30. The low response of females about the cost of condom is because they do not actually purchase condom. They believed that using condoms requires male agreement. Condoms are often seen as suitable for 'casual sex'

but inappropriate in the context of a long-term relationship. But this is one of the reasons why the HIV prevalence is very high in the study area. They have wrong perception about the importance of using condoms even if the relationship is long term. However on the availability of condom, majority of the male respondents indicated that condoms are available and they have access to it. This would have been good indicator in reducing the sexually transmitted infections in the study area if they normally used condom.

TABLE 4.14 Percentage Distribution of Respondents by Cost and Availability of Condom by Sex

VARIABLES	**MALE (N=731)**	**FEMALE (N=627)**	**TOTAL (N= 1358)**
How much did you buy a packet of condom			
N 20	47.5	25.2	37.2
N30	18.1	-	9.7
Don't know	34.4	74.8	53.1
Total	100	100	100
Is it Available			
Yes	55.1	31.0	49.1
No	12.1	-	9.1
Don't Know	32.8	69.0	41.8
Total	100	100	100

Source: Author's field survey, 2005

SUMMARY

The background variables examined in this chapter provide a broad understanding of the general characteristics of the populace, knowledge and awareness about HIV/AIDS, sexual behaviour, and susceptibility. Some of the socio-demographic variables examined in this chapter include, place of residence, age of the respondents, level of education, marital status, ethnicity, religion, age at first intercourse, knowledge about HIV/AIDS, mode of transmission of the disease, awareness about the people living with HIV/AIDS and the availability of condom.

Majority of the respondents are in age group 25 –34 years which shows that the population is economically active. The marital status revealed that more than two –thirds of the sample population are married, while more females indicated that they are divorcee than male respondent. This shows the changes in the cultural values regarding divorce and separation in South- Western Nigeria. It also reveals the heterogeneous nature of the study area. Also, forty-one percent of the females reported that their husbands have other wives and out of these only 27% are living together with their husbands. Women under this condition will receive little attention from their husbands and they have no power to negotiate sex with their husbands even when they are at risk.

There is high level of literacy in the study area, as 91 percent of the female respondents and 82 percent of male respondents had received formal education. Males seem to have higher education than female respondents. The data also show that three out of five respondents are Christians while only 1.9 percent are adherent of indigenous religion. It revealed the impact of proliferation of churches and mosques in the study area. Income is used to measure the economic power of the respondents. More than two thirds of the respondents are earning less than $1 a day which shows the level of poverty in Nigeria. Less than 5% of the female population earn above N360, 000 per annum. More than half of the respondents are in sale services, while a higher percentage of the female respondents are in civil/public service.

Expectedly the majority of the respondents are Yorubas. This is due to the fact that Yoruba ethnic nation is dominant in the area. The housing inventory of the respondents revealed that more that half of the sampled population sleep in one room, while about twenty percent are living in two or three- bed room apartment. On the knowledge of HIV/AIDS, nearly all the respondents have heard of the disease. Eighty percent are aware of the mode of transmission of the disease. One-quarter of the male respondents, and less than 5% of female respondents reported that they are negative while others do not know their HIV/AIDS status. The respondents are afraid of the test. This shows that there is not enough information about the VCT in the study area.

More females than males knew someone that is living with HIV/AIDS in the study area. One would also expect an increasing proportion of respondents who knew someone who died of AIDS, but less than five percent of the sample population knew someone that died of HIV/AIDS.

CHAPTER FIVE

SEXUAL BEHAVIOUR AND NETWORKING IN THE STUDY AREA

It is significant to understand the levels, patterns and sexual practices and behaviour of a society. These determine the spread of STIs, including HIV/AIDS. In Nigeria, where heterosexual relationship is the main mode of HIV/AIDS transmission, sexual behaviours have been implicated in the rampant spread of the epidemic. This chapter presents results from the various questions asked the respondents about their sexual behaviour, including information about the most recent non –marital relationship in the last twelve months, how various groups are linked together through common sexual partners, the risk behaviours of these people and their knowledge about STIs infection and treatment. The chapter also provides some insight into factors influencing the spread of HIV/AIDS in the study area. The relationship between some selected variables and other dependent variables like the use of condoms, susceptibility and bio-medical factors will also be examined in this chapter.

5.1 Extra-marital Sexual Relations.

Since there is a link between heterosexual relation and HIV/AIDS, respondents were asked whether they engage in extramarital sexual relations. More than two- thirds of the male respondents and half of the female respondents extramarital sex in the last twelve months. This shows that heterosexual relationship is high in the study area. It implies that there is high-risk of transmission of STI. The result is expected as previous studies such as those of Orubuloye (1999) and UNICEF (2001) have shown that there is high extramarital sexual activity in urban

centres in Nigeria, especially Lagos. They observed that more than half of the respondents' interview had extramarital relations which is in line with this study. Studies have shown that this type of sexual interaction is responsible for the high rate of HIV infections in the study area. Abanihe (1994) explained that although AIDS awareness is high in urban Nigeria, a substantial number of people still engage in high-risk sexual behaviour by continuing to have casual sex, or by having multiple partners, and doing so without using condom due to the level of poverty and poor economic situations in the country.

Table 5.1 Percentage Distribution of Respondents who had had Extra Marital Sexual Relations.

	MALE (N=731)	**FEMALE (N= 627)**	**TOTAL (N=1358)**
Had Sex in the last 12 months			
Yes	64.6	47.2	55.6
No	35.4	52.8	44.4
Total	100	100	100

Source: Author's field survey, 2005

5.6 Number of Sexual Partners in the last 12 Months Preceding the Survey

Multiple sexual partners increase the risk of being infected with HIV/AIDS and other STIs. Table 5.2 shows information on the number of sexual partners had in the last twelve months. The survey revealed that 15 percent of male, and 42 percent of female respondents had sex with only one partner, while three-quarters of male respondents and one-third of female respondents have had more than two sexual partners. This is an important finding as far as this study is concerned. It shows that despite the high level of awareness about the HIVAIDS, people still continue engaging in unhealthy social practices, which promote the spread of STIs

and HIV/AIDS. This finding is in line with some previous studies, for example, Orubuloye *et al* (2000), observed that two-third of the married men had engaged in extramarital affairs.

Table 5.2 Percentage Distribution of Respondents' By Number of Sexual Partners by Sex in the 12 months preceding the survey

	MALE (N =472)	**FEMALE (N= 283)**	**TOTAL (N= 768)**
Number of Partners having sexual Intercourse with			
1	15.0	42.0	24.0
2	10.0	22.2	15.3
3 +	74.1	37.4	60.0
No	0.9	0.4	0.7
Total	100	100	100

Source: Author's field survey, 2005

Types of people with whom Sexual Intercourse was had within the Last Twelve Months by Sex

The type (s) of people engaging in sexual relations is a crucial factor in terms of transmitting STI especially when it is unprotected sex. Table 5.3 reveals the level of risk taking by the respondents. From the survey, 34.3 % of those who had extramarital and premarital sex among male respondents had it with their girlfriends, while 37.1 % of female respondents had intercourse with man-friends. Four out of every five male respondents and three out of every five female respondents had intercourse with casual partners. None of the female respondents claimed to have engaged in prostitution. From the above findings, it shows that most of those who had intercourse in the last 12 months preceding the survey with casual partners, which is a sign of danger in the study area and may result in increase the prevalence of HIV/AIDS in the

study area. Caldwell *et. al,* (1999) in the study of obstacles to sexual behavioural change in Nigeria observed that the number of different sexual partners over a lifetime was around ten among men in the South West of Nigeria, in the past three years preceding the survey. However, those who visited prostitutes believed that it was necessary to satisfy an overwhelming urge, which is biological in nature.

Table 5.3 Percentage Distribution of Types of People Having Sexual Intercourse within the Last Twelve Months by Sex

	MALE (N= 472)	FEMALE (N= 296)
Girl friends/Man Friends		
Yes	34.3	37.1
No	65.7	62.9
Total	100.0	100.0
Casual Partner		
Yes	85.8	64.7
No	14.2	35.3
Total	100.0	100.0
Prostitutes		-
Yes	10.6	-
No	89.4	-
Total	100.0	-

Source: Author's field survey, 2005

5.4 SEXUAL NETWORKING

People who move away from their homes may likely do things they would not do while they are at home. National HIV/AIDS and Reproductive Health Survey (2003) explained that people who travel from home may likely to engage in risky behaviour. In most cases, they find themselves in circumstances which tempt them or force them to indulge into prostitution, extramarital and premarital sex. Respondents were asked where they had extra-marital sex.

From the survey, half of the male respondents and two-fifths of female respondents have the affairs within the same city. The percentage of female respondents that had intercourse in other urban centres doubled the number of male respondents, while more male respondents had sexual intercourse in the rural areas. This supports the suggestion make by Oppenhein-Mason (1994) on how HIV spread to rural communities. Men from the city normally entice the rural women with money and lured them into sexual relations, which may in turn increase the chances of opportunistic infections in the rural area. This is an avenue from which sexually transmitted infections are transmitted from one place to another.

The respondents were asked why they were in the other place in which they had extramarital sex. More than half of the respondents were in that place for economic reasons, while only 12 percent and 6 percent of females and males respectively were there for family reasons. Freudenthal (2001), explained that with increasing poverty and unemployment, the spread of HIV/AIDS will continue as people, especially young girls and boys, are forced to move from one place to another looking for means of survival. Young girls seen on the streets during the day time in cities become commercial sex workers at night. Also, in trying to escape from social, economic and political hardship, people move from one place to another carrying with them sexually transmitted infections, and HIV/AIDS. Many rural impoverished households have household members who work in urban or industrial areas or on large-scale, commercial farms. Being separated from their families for long period of time, these people often find new sexual partners, or form new families. Since employment opportunities in towns and industrial

areas are usually very limited, this leads to the creation of an urban class of very poor men and women whose way of life may involve many sexual partners. For women, this can be a survival strategy, and as long as there are no realistic alternatives in terms of other income generating activities, women will continue to engage in risky sexual activities (Packard and Epstein, 1991; McGrath *et. Al,* 1993, Schoeff, 1995; Preston-Whyte 1995b; Aggleton, 1996; UNAIDS, 2000)

When asked about their length of their relationship with their sexual partners, most of the respondents had known him for less than last 12 months. More females than males indicated relationship is less than twelve months. Three-quarters of male and one-quarters of female respondents, reported that the relationship is no longer going on between them and their sexual partners. It reveals that there is high concurrent changing of partners among the respondents in the study area and this may lead to increase in the spread of sexually transmitted infections. Studies have confirmed that having concurrent partners is one of the risky behaviours that can increase the spread of HIV/AIDS (Orubuloye, 1999, Adegbola and Oni 2000).

Table 5.5 Percentage Distribution of Respondents by Sexual Networking

	MALE (N= 427)	**FEMALE (N= 296)**	**TOTAL (N=725)**
Where did you have the sex?			
Same City	53.4	43.8	49.2
Other Urban Area	25.4	50.4	35.6
Rural areas	21.2	6.8	15.2
Total	100.0	100.0	100.0

Why were you there?			
Economic reasons	75.0	53.4	65.9
Professionals	18.2	26.5	21.5
Family	6.8	20.1	12.6
Total	100.0	100.0	100.0
***How long were you there?**			
Less than 12 months	63.0 (269)	66.78 (189)	63.2 (458)
12 months and above	37.0 (135)	33.22 (107)	36.8 (242)
Total	100.0 (404)	100.0 (296)	100.0 (700)
How long have You know him/her?			
Less than 12 months	57.0	64.3	60.0
12 months and above	43.0	35.7	40.0
Total	100.0	100.0	100.0
Is the relationship still on			
Yes	28.4	74.9	47.3
No	71.6	25.1	52.7
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

5.5 CONDOM USE WITH SEXUAL PARTNERS

Condoms are the only proven barrier method for reducing the risk of all sexually transmitted infection including HIV. They can be used for dual protection against unintended pregnancy and sexually transmitted diseases. As a result of the important role condom plays in preventing HIV transmission, respondents were asked whether they used condom in their last sexual intercourse. Fifty-five percent of the respondents used condoms during the last intercourse while others did not. This pattern revealed the sexual risk behaviour in the study area and this has great implications for HIV transmission in the area. Since there is the possibility of encountering infected partners in the sexual relationship and most of the unstable partners will

not disclose their STIs status to other partners. Zellner (2003) reported that the stigma associated with condom use inhibits persons in extramarital sexual relationships from protecting themselves and their partners. He further explained that regular use of condom during sexual encounter in extramarital relations is uncommon. In addition, in a study of male truck drivers in Nigeria, 72% of married men reported having multiple extramarital sexual partners, and 60% reported being unwilling to use condom because they did not like using them or unaware of the risks of unprotected sex (Araoye *et. al* 1996).

Frequency of use of condom is another important factor that will determine the rate of transmission of HIV/AIDS. Twenty-one percent of the male respondents reported that they used condom always while sixty percent of female respondents indicated that their sexual partners used condom always. This indicates that the females are now conscious of the importance of using condom. This is a desirable development given the proven role of condom in preventing the spread of HIV/AIDS.

Table 5.6 PERCENTAGE DISTRIBUTION OF RESPONDENTS BY CONDOM USE AND USE OF ALCOHOL

	MALE (N= 427)	**FEMALE (N=296)**	**TOTAL (N=725)**
In your last intercourse did you use condom?			
Yes	56.2	55.1	55.7

No	43.8	45.9	44.3
Total	100.0	100.0	100.0
Did you usually use condom?			
Always	21.6	59.7	54.22
Most of the Time	36.8	30.7	32.67
Rarely	41.3	9.6	13.11
Never	0.3	-	-
Total	100.0	100.0	100.0
Did you or your partner take alcohol before sex?			
Yes	55.1	36.8	47.8
No	45.9	63.2	52.2
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

Sexual acts under the influence of alcohol may allow infections as proper care towards taking preventive measures, such as correct and consistent use of condom are not likely. Fifty-five percent of male and 36.8 of female respondents respectively indicated that they or their partners drank alcohol before intercourse. A sizable proportion of respondents thus indulge in practices that encourage the spread of HIV/AIDS. Gifford *et.al* (1999) in their study of risk and perception among young people and women in Churachandpur, India, observed that drinking the local alcohol "Zu", a rice beer, was related to sexual activity. Many sexual relationships begin here because as they drink Zu together, the girls' are drunk faster than boys and many of the boys use such period to initiate sexual activities. Taking of alcohol can be one of the reasons for the low use of condoms among the respondents. They would have been intoxicated with alcohol and sexually aroused.

5.7 Distribution of Respondents and how often they offer money for sex.

	MALE	FEMALE	TOTAL
Did you always receive /give money for sex			
Yes (Always)	67.9 (273)	29.8 (84)	50.3 (357)
Yes (often)	32.1 (129)	70.2 (198)	49.7 (327)
Never	-	-	-
Total	100.0 (412)	100.0 (282)	100.0 (684)

Source: Author's field survey, 2005

5.7 PAYMENT FOR SEXUAL RELATIONS

Among the respondents who have ever had sexual intercourse, Table 5.7, shows the percentage of males and females who gave or received money, gifts, or favour in return for sex in the last twelve months. Sixty-eight percent of male, and 30% of female, respondents report that they always had such an exchange, while more females than males indicated that they often have such exchanges for sex. This aspect of encounters involving payment for sexual favour is an indication of commercialization of sex in the study area, especially when prostitution and sex houses are illegal. Such development might be attributed to increasing poverty levels in the country. Adepoju (2004), explained that poverty leads some adolescents to engage in commercial sex: Economic vicissitude and the drive for survival lured some adolescents to engage in commercial sex. Forced to depend on men, young girls exchange sex for money or other gifts, sometimes with older men who may be infected with HIV.

The exchange of gifts is significant in the creation and maintenance of social relationships, especially sexual relationships among many groups of people in Africa. Haram (1995), reports from a study amongst the Meru people in Northern Tanzania, that for most young Meru

women, sexual relationships are their only means to gain access to items like soap, body lotion, shoes, nice dresses and money. Before marriage, both men and women tend to have many sexual partners. According to Haram, there is high level of AIDS awareness among the Meru, but many women are still tempted to enter into sexual relationships because of the gifts men can offer them. The other concern is that a number of non-regular partners have other sexual relationships and are aware that their partners have other sexual partners. The increasing multiple partnerships are most likely to increase STIs, especially in the light of inconsistent use of condoms in the study area.

5.8 KNOWLEDGE OF SEXUALLY TRANSMITTED INFECTIONS

In this study, some questions were asked to access knowledge of STIs other than HIV/AIDS. Knowledge of sexually transmitted infections is universal among male and female respondents. All the respondents have heard of STIs before. The most widely reported STI among females apart from HIV//AIDS is syphilis, while gonorrhea is the widely known for male respondents. Although gonorrhea is the next most widely known sexually transmitted infection among women, Herpes and Candidiasis follow next among men in the study area.

The major source of their information is through the media, television and radio, while other sources are, friends (male 32.1%, female 36.8%) and Hospital (male 30.7%, female 19.6%). Those who had heard of STIs were asked to describe symptoms of STI in male and female. Correct STI symptoms for male and female were considered to be: abdominal pain, blood in urine, burning pain with urination, discharge from vaginal or penis, failure to pass urine,

genital ulcers or open sores, inability to conceive, itching in the genital area, loss of weight, pelvic pain during intercourse, and swellings in the genital area.

The respondents were also asked whether they had any sexually transmitted diseases in the last twelve months. The percentage of female respondents who reported that they contracted sexually transmitted disease (86.5%) is higher than male (36.9%). This is in conformity with the NDHS, 2003 report that women are more affected with the sexually transmitted diseases including HIV/AIDS than men. Those who indicated that they contacted STIs were asked how they knew, eighty-five percent of all the male respondents revealed that it was through medical examinations, while half of the female respondents knew their STIs status through itching of the private parts.

5.8 Distribution of Respondents by Knowledge of Sexually Transmitted Infections

	MALE (N=731)	**FEMALE (N = 627)**	**TOTAL (N= 1358)**
Heard of STIs			
Yes	100.0	100.0	100.0
No	-	-	-
Total	100.0	100.0	100.0
** **STIs Heard of**			
Gonorrhea	81.5	82.6	80.0
Syphilis	44.6	86.3	59.9
HIV/AIDS	100	100	98.6
Herpes	55.4	81.5	68.6
Candiasis	55.4	80.5	68.6

** Symptoms of STIs			
Abdominal pain,	30.1	30.2	30.0
Blood in urine,	25.4	28.9	26.4
Burning pain with urination,	28.9	45.2	35.3
Discharge from vaginal or penis,	27.6	23.5	24.5
Failure to pass urine,	35.8	25.7	29.4
Inability to conceive,	25.2	25.1	25.0
Itching in the genital area,	45.8	45.7	45.0
Loss of weight,	24.8	28.4	25.3
Pelvic pain during	32.5	05.	19.4
Swellings in the genital area.	54.2	35.2	46.7
Genital ulcers or open sores,	56.4	35.8	42.3
** Sources			
Television/Radio	59.5	37.5	49.3
Friends	32.1	36.8	34.3
Health centre/Hospital	30.7	19.6	22.0
Contracted STIs			
Yes	36.9	86.5	58.6
No	63.1	13.5	40.0
Total	100.0	100.0	100.0
***How do you know**			
Through medical examination	85.2 (230)	5.6 (24)	36.3 (254)
Inching	4.4 (12)	62.7 (270)	40.3 (282)
Vaginal or Penis discharge	10.4 (28)	-	4.0 (28)
Burning pain with urination	-	31.7 (136)	19.4 (136)
Total	100.0 (270)	100.0 (430)	100.0 (700)

Source: Author's field survey, 2005 ** Multiple Response are allowed

* Excluding Non Response Category

5.9 TREATMENT SEEKING BEHAVIOUR OF STIs

Treatment of sexually transmitted infections is one of the ways to reduce the transmission of HIV/AIDS. Respondents who reported that they contracted STIs in the last twelve months were asked whether they sought treatment. Ninety percent of males and 78% of female respondents did. The high rate in number (79.4%) of respondents seeking treatment may not be

unconnected with the level of awareness of STIs and the influence of urbanization in the study area and availability and access to medical services. The differences between male and female in terms of seeking treatment may be related to the stigma attached to these STIs. To many people, it shows that the woman is not faithful to her husband. This can make the woman unwillingly to disclose her STI status and seek treatment. Previous studies have shown that women with sexually transmitted infections are more likely to be asymptomatic and therefore less likely to seek treatment (Cates *et.al* 1998, and WHO, 2002).

The consequences of undetected and untreated STIs including HIV are devastating, and include cancer, infertility, ectopic pregnancy, miscarriage, social stigmatization and premature death imposing huge economic and social burden (Cates *et .al* 1998). The majority of those who sought treatment among the respondents do so in the government hospitals, while more female respondents sought treatment from traditional healers. The latter may be due to the fact that women normally visit traditional birth attendants for childcare and treatment. Cost of treatment of STIs ranges from N1,000 - N1,999 and more than half of the respondents spend above N2000 for the treatment of STIs. These money would have been spent on something else which will have better economic value.

Table 5.9 Distribution of respondents According to Treatment Seeking Behaviour of STIs

VARIABLE	**MALE (N = 270)**	**FEMALE (N =526)**	**TOTAL (N=796)**
Did you seek treatment?			
Yes	90.3	78.3	79.4
No	9.7	26.2	20.6
Total	100.0	100.0	100.0

Where did you seek treatment?			
Government Hospital	64.3	65.8	65.5
Private hospital\Clinic	23.9	24.1	24.1
Health workers	6.6	3.0	4.3
Traditional	5.1	7.0	6.1
Total	100.0	100.0	100.0
How much did you spend?			
Less than N2,000	44.4	31.2	35.7
Above 2000	55.6	69.8	64.3
Total	100.0	100.0	100.0

Source: Author's field survey, 2005

5.10 BEHAVIOUR EXHIBITED WHEN INFECTED WITH SEXUALLY TRANSMITTED INFECTIONS

Communication between sexual partners is important with regard to sexually transmitted infections in order to prevent infection and reinfection between them. Women often have little control over the mode of sexual relations or the behaviours of their partners. Gender issues, such as power imbalances in sexual relationships, may interfere with condom use and may prevent women from protecting themselves, even if they are aware that their partners' behaviour may be putting them at risk. Respondents were asked if they informed their partners about their STIs status. Half of the female respondents, and 44 percent of the male respondents informed their partners about their infections. This is contrary to the expected pattern compared with the previous finding where women would not be able to tell their partners about their infections. Surprisingly, majority of the female respondents did not do anything to prevent the infection from being contracted by the sex partner. This shows that there is the

likelihood of transmitting the infection to their partners. Women also do not have the courage to tell their husbands to use condom.

On what they do in order not to transmit the infection, 66% of females and 56% males used condom, while more males (43.3%) than females (32.7%) abstain from sex. The finding revealed that even though the partners were informed about the infections, females couldn't abstain from sex unless their husbands cooperated.

TABLE 5.10 Percentage Distribution of Respondents by Behaviour Exhibited during Sexually Transmitted Infection

VARIABLE	**MALE (N=270)**	**FEMALE (N=526)**	**TOTAL (N=796)**
Did you tell your spouse?			
Yes	44.5	51.5	49.0
No	55.5	48.5	51.0
Total	100	100	100
*** Did you do anything to prevent it ?**			
Yes	64.9 (157)	16.1 (75)	38.9 (232)
No	35.1 (85)	83.9 (391)	61.1 (476)
Total	100 (242)	100 (467)	100 (709)

What did you?			
Use Condom	56.7	66.0	59.9
Abstain from sex	43.3	32.7	40.5
Others	-	1.3	0.6
Total	100	100	100

Source: Author's field survey, 2005. * Excluding non response category

5.11 PLACE OF RESIDENCE AND EXTRA-MARITAL SEX IN THE LAST 12 MONTHS

Place of residence influences the extramarital affairs and has impact on the sexually transmitted disease including HIV/AIDS. Commercial sex is known to exist more in the urban areas where people are anonymous. In many societies, urbanization increases opportunities for sexual encounters. Urbanization throws overboard the traditional values that are more dominant in the rural areas. From Table 5.11, more males in semi-urban (64.1%) and urban centres (65.5%) had sexual intercourse compared with their counterparts in the rural areas (62.0%) while half of females in the urban centre had sexual intercourse. Cleland (1995), in his study on extramarital sex found that there was high level of sexual activities with non-regular partners in the urban settings than in rural areas. These findings show to what extent much place of residence determines individual reproductive behaviour and thus affect HIV/AIDS. It also shows that there is a significant relationship between place of residence and extramarital sex (P value for males is 0.000 and 0.032 for females)

5.12 AGE OF RESPONDENTS AND EXTRA-MARITAL SEX IN THE LAST 12 MONTHS

Age is an important variable in sexual behaviour. From Table 5.11, 78.6 percent of females between ages 15-24 years and 49.3 percent of males of the same age category had sexual intercourse with other partners apart from their spouse in the last twelve months preceding the survey. It implies that young females are more involved in extramarital affairs than males. A lot of factors can be responsible for this, observation as not being satisfied with a relationship, poverty and peer influence. Twa-Twa *et.al* (1997), found out in their study on female sexual partner instability, that a reasonable proportion (37 percent) of sexually active young women aged 15-39 years in Uganda are dissatisfied with sexual relationships, a fact which may account for multiple sexual partners and the spread of HIV/AIDS. Sexual intercourse with partner apart from spouse increases with age among the male respondents while about seventy-eight percent of female respondents who had sexual intercourse are below 34 years. The decrease in the number of females above thirty having extramarital affairs, may be due to the fact that they are new in marriage.

Caldwell *et.al* (1993), in a study conducted in Ijebu-Ode South West Nigeria, showed that the number of sexual partners drop as one marries. This shows that the young females are more prone to sexually transmitted infection including HIV/AIDS. Interestingly, the proportion of women in older ages, who are involved in extramarital affairs, is higher than those in the lower ages. Orubuloye et. al (1994) confirmed in their study of obstacles to behavioural change in Nigeria that Yoruba wives seek additional support, economic and even emotional, for

themselves and their children from shorter or longer term relations with men other than their husbands. Sexual relations form part of this support.

5.13 MARITAL STATUS AND EXTRA MARITAL SEX IN THE LAST 12 MONTHS

Studies carried out in many parts of Africa have shown that marital status plays an important role in influencing the number of sexual partners an individual has (Twa-Twa *et.al* 1997; Isuigo- Abanihe, 1993 and Araoye *et.al* 1996). Eighty percent of married men were involved in extramarital affairs while 88% of females who are single had premarital sex with other men apart from their partners. The large number of men involved in extramarital affairs believed that they cannot be satisfied with one woman (Orubuloye *et.al* 1995). Females who are divorced and who get involved in extramarital affairs are more in number than their counterparts who are married. Since they are free from any marital obligations or bonds they are free to use their body as they like. Some even engage in these relationships for exchange of money and gifts.

5.14 RELIGION AND EXTRA MARITAL SEX IN THE LAST 12 MONTHS

Religion has a lot of influence on the life of individual. Seventy percent (72.7%) of males who are Christians and 43.7% of males who are Muslims engaged in extra marital sex 12 months preceding investigation The reasons for the higher number of Christian males can be connected with the fact that most of them are in monogamous marriages which limited them to one woman compared with their Muslim counterparts who have many wives because their religion

accommodates it.. They have variations and they can make choices among their wives at a particular time. Also, among female respondents the variation can be due to the fact that Muslim women may not be satisfied with their relationships since their husbands may have other wives which are supported by Islamic tenets. This can lure the women into extramarital affairs.

Table 5.11 Distribution of Respondents by Socio-Economic Characteristic and Having Sexual Intercourse Apart from Spouse in the Last 12 Months by Sex

VARIABLES	MALES			FEMALES		
Place of Residence	Yes	No	Total	Yes	No	Total
Urban	65.5(177)	34.5 (98)	100 (274)	50.5 (115)	49.5 (110)	100 (225)
Semi-Urban	64.1 (169)	35.9 (78)	100 (248)	44.4 (89)	45.6 (115)	100 (204)
Rural	61.7 (128)	38.9 (81)	100 (209)	46.4 (93)	53.6 (105)	100 (198)
Age						
15-24Yrs	49.3 (35)	51.7 (38)	100 (73)	78.6 (110)	15.1 (30)	100 (140)
25-34Yrs	44.4 (115)	55.6 (114)	100 (259)	29.2 (102)	63.4 (247)	100 (349)
35-44 Yrs	98.6 (140)	1.4 (5)	100 (145)	72.7 (16)	27.3 (5)	100 (22)
45 and above	70.4 (182)	29.6(72)	100 (253)	39.2 (69)	60.8 (109)	100 (178)
Marital Status						
Single	44.1 (119)	55.9 (151)	100 (270)	88.9 (104)	21.1 (14)	100 (118)
Married	80.2 (325)	19.8 (83)	100 (408)	51.6 (121)	48.4 (118)	100 (239)

Divorced	50 (28)	50 (28)	100 (56)	41 (56)	59.0 (81)	100 (137)
Widow/Widower	-	-	-	10.7 (15)	89.3 (118)	100 (133)
Religion						
Christianity	72.7 (370)	27.3 (139)	100 (509)	42.7 (131)	57.3 (178)	100 (309)
Islam	43.7 (92)	56.3 (120)	100 (212)	50.3 (152)	49.7 (150)	100 (302)
Traditional Religion	100 (10)	-	100 (10)	100.0 (16)	-	100 (16)
Income						
< N120,000	57.5 (235)	42.5 (96)	100 (408)	56.7 (263)	57.3 (201)	100 (464)
N121,000- 240,000	83 (105)	17 (30)	100 (135)	17.1 (12)	82.9 (57)	100 (69)
N241 & above	87.2 (132)	12.8 (56)	100 (188)	22.0 (21)	78.0 (73)	100 (94)
Education						
None	69.1 (94)	30.9 (42)	100 (135)	52.2 (29)	47.8 (27)	100 (56)
Primary	57.0 (62)	43.0 (48)	100 (110)	45.5 (80)	44.5 (96)	100 (176)
Secondary	61.5 (130)	38.5 (84)	100 (214)	50.0 (90)	50.0 (90)	100 (180)
Post Secondary	70.0 (188)	30.0 (84)	100 (272)	57.7 (97)	42.3 (71)	100 (168)
Occupation						
Trading	56.1 (229)	43.9 (179)	100 (408)	49.0 (169)	51.0 (176)	100 (345)
Public/Civil Servant	61.5 (83)	39.5 (52)	100 (135)	20.3 (27)	79.7 (108)	100 (135)
Artisans	83.0 (78)	17.0 (16)	100 (94)	66.7 (44)	33.3 (22)	100 (66)
Professionals	87.2 (82)	12.8 (12)	100 (94)	80.0 (24)	20.0 (6)	100 (30)
None	-			64.0 (32)	36.0 (18)	100 (50)

Source: Author's field survey, 2005.

5. 15 INCOME AND HAVING SEXUAL INTERCOURSE APART FROM SPOUSE IN THE LAST 12 MONTHS

Income is being considered as one of the factors influencing sexually transmitted infections. It is the poor women and men that are most susceptible to HIV infections. Fifty-six percent of females who earn less than N120,000 had intercourse with person apart from their partners, while fifty-seven percent had intercourse among males. The table revealed that income increases with extramarital affairs among male respondents. Women who are economically

empowered are less likely to be involved in extramarital affairs. From the above result, 20 % of women with higher income report that they had sexual relations. Men with high income have money to lure young females into sexual relations. “Sugar daddies” and “sugar mummies” use their wealth and influence in the society to attract young girls and boys for companionship and sexual relations. Kisekka (1992), in a study of Baganda and Hausa people, observed that women had little or no bargaining power in sexual matters because they were poor, ill educated and economically dependent on their sexual partners.

5.16 OCCUPATION AND HAVING SEXUAL INTERCOURSE WITH PARTNER APART FROM SPOUSE IN THE LAST 12 MONTHS

Women are more vulnerable to HIV/AIDS because they have less-secured employment, lower income (if any), less access to health care and social security, less entitlement to assets and savings than men, and little power to negotiate sex. From table 5.11, 64% of women who did not engage in any economic activity had sexual intercourse with casual partners. Among males, 87% of those who are professionals engaged in sexual relations, these are the people who will have the resources to entice women into sexual relationships.

5.17 EDUCATION AND HAVING SEXUAL INTERCOURSE WITH PARTNER APART FROM SPOUSE IN THE LAST 12 MONTHS

Education is another important variable. The education of both male and female respondents followed the same pattern. Those respondents with no education and those with post secondary

have more extramarital affairs. The reason is that those with no education may not know or have good knowledge about the danger involved in risky behaviour, while those with higher education have the economic power and may think that they are not at risk. Also, those with no education include a large number of merchants, semi-skilled and entrepreneurs, many of whom are considered wealthy by Nigerian standards and can, therefore, afford the cash which many of their extramarital partners demand. On the other hand, men with some tertiary education constitute the social and government elite whose work experience is more likely to expose them to high risks of extramarital overtures (Abanihe, 1994)

The result of this analysis shows that place of residence, income, education; age, marital status and religion were significantly associated with having sexual intercourse apart from spouse in the last twelve months that preceded the survey.

Table 5.12 Distribution of Respondents by selected characteristics and the Use of Condom and by Sex

VARIABLES	MALES			FEMALES		
Place of Residence	Yes	No	Total	Yes	No	Total
Urban	56.5 (100)	43.5 (77)	100 (177)	68.6 (78)	31.4 (37)	100 (115)
Semi-Urban	49.1 (83)	50.9 (86)	100 (169)	67.0 (59)	33.0 (30)	100 (89)
Rural	44.5 (57)	45.5 (71)	100 (128)	27.0 (26)	73.0 (67)	100 (93)
Age						
15-24Yrs	34.2 (12)	65.8 (24)	100 (36)	61.7 (67)	38.3 (43)	100 (110)
25-34Yrs	50 (57)	50 (57)	100 (114)	64.9 (61)	35.1 (41)	100 (102)
35-44 Yrs	53.1 (171)	46.9 (151)	100 (322)	63.8 (40)	36.2 (29)	100 (69)
Marital Status						
Single	54.6 (65)	46.4 (54)	100 (119)	65.4 (68)	34.6(36)	100 (104)
Married	46.7 (152)	53.3 (173)	100 (325)	43.8 (53)	56.2 (68)	100 (121)
Divorced	82.0 (23)	18.0 (5)	100 (28)	70.4 (42)	29.6 (29)	100 (71)
Widow/Widower	-	-	-			

Religion						
Christianity	51.4 (190)	48.6(180)	100 (370)	43.5 (57)	56.5 (74)	100 (131)
Islam	51.0 (47)	49.0 (45)	100 (92)	70.4 (106)	29.6 (46)	100 (152)
Traditional Religion	33.3 (3)	66.7 (7)	100 (10)	-	-	-
Education						
None	-	-	-	34.5 (10)	65.5 (19)	100 (29)
Primary	55.8 (48)	44.2 (45)	100 (92)	50 (40)	50 (40)	100 (80)
Secondary	87.8 (54)	12.2 (8)	100 (62)	60 (54)	40 (36)	100 (90)
Post Secondary	73.4 (138)	26.6 (50)	100 (188)	60 (59)	60 (38)	100 (97)
Occupation						
Trading	53. 7 (123)	46.3 (106)	100 (229)	53.8 (91)	46.2 (78)	100 (169)
Public/Civil Servant	48.0 (40)	52.0 (43)	100 (83)	51.8 (14)	48.2 (13)	100 (27)
Artisans	48.9 (38)	51.1 (40)	100 (78)	58.3 (14)	41.7 (10)	100 (24)
Professionals	47.8 (39)	52.2 (43)	100 (82)	69.0 (20)	21.0 (9)	100 (29)
None	-	-	-	65.6 (21)	34.4 (11)	100 (32)

Source: Author's field survey, 2005.

5.18 Condom Use and Place of Residence

Condom use is another indicator of behavioural change. Studies have shown that condom use has strong association with place of residence. Table 5.12 shows that urban residents use condom more than their counterpart from the rural area. Respondents in the urban areas are more likely to have access to condom than those in rural areas. . This is also in line with the general trend that has been found in most studies, that urban dwellers are generally more inclined to contraceptives than their rural counterparts. This may not be unconnected with the low level of education of people in the rural areas, and the fact that those in the urban areas are likely to be more knowledgeable about condom use.

5.19 CONDOM USE AND AGE OF RESPONDENTS

Some studies have established that there is a close relationship between age and condom use (Ogunjuyigbe, 2001). From the table, the use of condom increases with age, 34.2% of male in

age group 15 –24 use condom. The relatively low level of condom use in this age group indicates high levels of risky behaviour among the young people in the study area. Gifford, *et.al* (1999) in their study of social context of risk and protection amongst young people in India observed that it is not that young people lack knowledge about the use of condom to prevent STIs including HIV/AIDS, but other factors act as barriers to condom use such as social pressure not to carry condoms and not to buy condoms and, the feeling that it spoils the fun and enjoyment of the sexual intercourse. Ironically, 63% of female respondents above 35 years indicated that their partners used condom in the last sexual intercourse. The reason is to prevent the unwanted pregnancy and some of them are also not living with their husbands. Abanihe (1994) explained that the higher level of extramarital affairs among older women is probably related to their stage in the life cycle; most of their children have grown up or left home so they have more time to socialize outside their homes. Many of these women are actively involved in economic pursuits such as government contracts and large-scale commercial enterprises, and therefore they are wealthy and also exhibit independence in their personal behaviour.

5. 20. CONDOM USE AND MARITAL STATUS

Condom use varied among respondents with different marital status. The married would use the same to space or limit births. The widows, divorced or separated would use condom to prevent pregnancies and STIs since they are in no socially acceptable union. Table 5.12 shows that condom use is higher among the respondents who divorced (males 82%, females 70.4%).

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Since they are not in unions they probably use condom to prevent pregnancy. This is to reduce the risk of unwanted pregnancy. The proportion of the single using condom (males 54.6%, females 65.4%) is also higher than the married respondents (male 46.7%, female 43.8%). There is low use of condom among the married. Weiss and Udo (1979), reported that in rural Cross River state, the contraceptive users (condom) included the unmarried women, comprising the separated, the divorced, but with children.

5.21. CONDOM USE AND EDUCATION

Education is an important factor influencing the use of condom. Studies have shown that the level of education influences condom use (Adegbola and Oni 1999, Orubuloye et. al 1999). This fact has been sustained in this study, where the rate of condom use increases with educational attainment among the respondents. People with primary education may not have enough information about condom and they may likely not practice safe sex. Except those with none education, the number of male respondents that used condom in the last sexual intercourse are higher than the female respondents. This may not be unconnected with the fact that women cannot dictate whether or not to use condoms. Lagarde, *et.al* (1998) in a cross-sectional population survey conducted in four cities in sub-Saharan Africa observed that condom use was associated with higher educational level of the partners. Okeibunor (1999), also in his study of condom use in Nigeria observed that more of those respondents with high levels of educational attainment would insist on the condom as a protective device against HIV/AIDS.

5.22 CONDOM USE AND RELIGION

Religious belief can affect individual's perception, attitudes and practices of safer-sex. Some religious groups like the Catholics, Muslims, Pentecostals are known to be against the use of condoms because they believe that it promotes promiscuity among youths and extramarital affairs among married couples. From table 5.12 only half of the male respondents who are Christian and Muslims used condom, while the least users are males who are traditionalists. The reasons for this can be attributed to the fact that most Christian couples are monogamous and condom is used with their sexual partners not for protection against STIs, but to avoid unwanted pregnancy. Among the female respondents, more Muslims use condoms than Christians in the last sexual relations. The changes in the pattern of condom use may not be unconnected with the greater awareness of HIV/AIDS as well as avoidance of unwanted pregnancy.

5.23 OCCUPATION AND CONDOM USE

Occupation, like education, can influence condom use. Review showed that economic empowerment influences the decision of women to insist on the use of condom. From table 5.12, the highest condom users among men are those in trading and the least users are the professionals. This pattern shows that those that have good job, who may also have higher education, may not likely use condom. The reverse is the case for the women who are professionals: 69% of such women used condom. The reason may be due to the nature of their

jobs. Organizations such as banks mandate child spacing up to four or five years. Surprisingly, 65.6% of women who are full-time house wife used condom in their last sexual relations. It may not be unconnected to avoid unwanted pregnancy since they do not have jobs. The pattern of the condom use among the respondents could also be as a result of the impact of education.

5.24 CONDOM USE AND AGE AT FIRST INTERCOUSRE.

Throughout the world, the age of puberty is falling, while the age of marriage is generally rising. These factors result in a longer period during which unmarried youth can be sexually active, often in a series of monogamous relationships. From table, 5.12 there is a direct relationship between the age at first intercourse and condom use, only twenty-one percent of females who had their first intercourse between ages 15-19 years used condom compared with 23% for males. Early initiation of sex may be unprotected. Males who reported condom use at age 25 years and above are higher than female respondents (Male 44.5% and female 53.0%). The difference is due to the fact that females do not have control on the use of condom especially those with low economic status. In demographic and health surveys among 15- 19 year old, more than 25 percent of boys in Brazil, Gabon, Haiti, Hungary, Kenya, Latvia, Malawi, Mozambique, and Nicaragua reported having had sexual intercourse before they were 15 years old. Generally, more than 15 percent of surveyed girls reported having had intercourse before age 15 (UNICEF, 2002). For behavioral as well as physiological reasons, early sexual debut increases adolescents' risk for infection with HIV and other STIs. Youths who begin

sexual activity early are more likely to have high-risk or multiple partners and are less likely to use condoms (WHO 2000).

5.13 Distribution of Respondents by Age at First Intercourse and Condom Use

VARIABLE	MALE(N = 405)		FEMALE (N= 203)		BOTH (N=608)	
	Yes	No	Yes	No	Yes	No
15-19 Years	23.5	76.5	21.0	79.0	17.3	82.7
20-24 Years	40.9	59.1	37.5	62.5	38.9	61.1
25Years & Above	44.5	55.5	53.0	47.0	43.8	56.2
X^2	X^2 p value=0.12		X^2 p value=0.145			

Source: Author's field survey, 2005.

5.25 EVER CONTRACTED STIs AND PLACE OF RESIDENCE

As earlier mentioned, place of residence is an important factor influencing sexually transmitted infections. Studies have revealed that STIs are common among urban residence than in the rural areas. This has been confirmed in this study as shown in Table 5.14. From the table, respondent from urban area are likely to contract STIs than those in the rural areas. Female respondents in the rural area are likely to contract STIs compared to those in the semi-urban areas. This pattern can be related to the movement of husbands from the rural to urban centres in search of greener pasture and the impact of males coming home during festivity period, when urban males re-visit the rural areas. They can lure young females into sexual relations with money and gift.

Table 5.14 Ever Contracted STIs and Place of Residence

VARIABLES	MALES			FEMALES		
Place of Residence	YES	NO	TOTAL	YES	NO	TOTAL
Urban	37.9 (104)	62.1 (170)	100 (274)	90.6 (204)	9.4 (21)	100 (225)

Semi-Urban	37.5 (93)	62.5 (155)	100 (248)	83.1 (162)	16.9 (42)	100 (204)
Rural	34.9 (73)	65.1 (136)	100 (209)	85.1 (160)	14.9 (38)	100 (198)
	X^2 p value= 0.14			X^2 p value= 0.05		

Source: Author's field survey, 2005.

5.26 AGE AND EVER CONTRACTED STIs

Table 5.16 shows the relationship between age of the respondents and ever-contracted STI. From the table, 96.4% of female and 8.25% of male respondents have contracted STIs. This shows that young females are more at risk of contracting STIs since most of them are less likely to use condom and they are involved in risk behaviour. UNICEF (2002), explained that adolescents are particularly vulnerable because they are more likely to have multiple partners and less likely to prevent, or recognize, STDs. Among heterosexual adolescents, STD rates are higher for females than males, possibly because females are more likely to acquire an STD following a single act of unprotected intercourse with an infected partner: an estimated 50% of women will contract gonorrhea and 30% to 40% will contract chancroid, chlamydia, herpes, or syphilis . Moreover, sexually active adolescents have to deal with the threat of infection from the human immunodeficiency virus (HIV), which can lead to acquired immune deficiency syndrome (CDC, 1994) .

Table 5.15 Distribution of Respondents by Ever Contracted STIs and Age

VARIABLES	MALES			FEMALES		
AGE	YES	NO	TOTAL	YES	NO	TOTAL
15-24Yrs	8.2 (6)	91.8 (67)	100 (73)	96.4 (134)	5.6 (6)	100 (140)
25-34Yrs	0.8 (2)	99.2 (257)	100 (259)	76.8 (255)	24.2(94)	100 (349)

35 and Above	65.7 (262) X^2 P=0.019	34.3 (77)	100 (339)	100 (137) X^2 P=0.14	100 (137)

Source: Author's field survey, 2005.

5.27 MARITAL STATUS AND EVER CONTRACTED STIs

Table 5.16 describes the respondents' marital status in relation to whether they have ever contracted STIs. The table shows that 98.3 percent of the female respondents who are single have contracted STIs while the highest are those who are widows and the least are those who are divorced. The pattern corresponds to the previous findings that majority of the adolescents who are single are involved in unprotected sex. Widows have no more marital obligations. Therefore, they have the tendency to be involved in sexual relationships with multiple partners. On the other hand, 66.7 percent of those married men have contracted STIs and this shows that there are considerable extramarital relationships among men and women in the study area.

Table 5.16 Distribution of Respondents by Ever Contracted STIs and Marital Status

VARIABLES	MALES			FEMALES		
Marital Status	YES	NO	TOTAL	YES	NO	TOTAL
Single	-	-		98.3 (115)	1.7 (3)	100 (118)
Married	66.7 (270)	32.3 (135)	100 (405)	95.8 (228)	4.2 (11)	100 (239)
Divorced				41.2 (56)	58.8 (81)	100 (137)
Widow/Widower	-			100 (118)	-	100 (118)

Source: Author's field survey, 2005.

5.28 Education and Ever Contracted STIs

Education plays a vital role in sexually transmitted infections, and in changing reproductive behaviour. It is believed that those with formal education would have good knowledge of STIs and access to other health related matters. From table 5.18, sixty-nine percent of male respondents who did not have education contracted STIs, while the least are those with primary education. This shows that education has impact on whether one contracts STIs. The pattern among the female respondents was different from the male respondents, 94% of female respondents with primary education have contracted STIs while the least are those with no education (60%). This is an indication that women are highly vulnerable to STIs, regardless of their level of education. This may be largely cultural as women are not suppose to decide for their partners as to whether to use condom Power inequalities lead women to acquiesce to non -condom use even when they are convinced that their partner should use it.

Table 5.17 Distribution of Respondents by Ever Contracted STIs and Education

VARIABLES	MALES			FEMALES		
Education	YES	NO	TOTAL	YES	NO	TOTAL
None	69.1(76)	31 (59)	100 (135)	60.0(105)	30.0(15)	100 (118)
Primary	36.9(79)	63.1 (31)	100 (105)	94.0(166)	6.0 (10)	100 (176)
Secondary	-	100 (214)	100 (214)	64.3(108)	35.7 (60)	100 (168)
Post Secondary	42.2(115)	57.8 (157)	100 (272)	90.7(147)	-	100 (162)

Source: Author's field survey, 2005.

5.29 USE OF CONDOM AND EVER CONTRACTED STIs

Condom use during sexual intercourse, whether vaginal or anal, is a prime prevention tool against sexually transmitted infections (STIs). Correct and consistent condom use can also decrease the spread of the human immunodeficiency virus (HIV). Many organisms, including

HIV, cannot be transmitted through an intact condom worn during sexual intercourse. Findings from 10 cohort studies conducted in Western countries, which evaluated the efficacy of condom use among heterosexual couples, showed that consistent condom use could protect people against HIV infection (Feldblum, Morrison, Roddy, and Cates, 1995). Condoms may help prevent AIDS over the long term not only by blocking transmission of HIV, but also protecting against other STIs. For instance, people with genital ulcerative STIs such as cancroids, genital human papillomavirus, herpes simplex, and syphilis are two to seven times more likely to

become infected with HIV than people who do not have STIs (WHO, 2000).

Table 5.18, shows that 46% of male respondents who used condom contracted STIs while 63% of females contracted STIs. The analysis also shows that there is a significant relationship between condom use and contracting STIs among male respondents. Although the percentage of those who use condom in the last intercourse and were infected with STIs among female is very high, findings show that most of the users do not use it consistently especially when it involves relationships where one partner was a suspect. Pivnick (1993), in his study observed that the bonding associated with unprotected sex was so important that condoms were avoided even within relationships where one partner was a suspected or confirmed HIV carrier. Men and women appear to judge the emotional benefits of unprotected sex as more important than the risk of infection.

Table 5.18 Distribution of Respondents by condom use and ever contracted STIs by sex

VARIABLES	MALE	FEMALE
Yes	45.5 (120)	63.3 (205)
No	54.5 (150)	36.7(119)
Total	100.0	100.0
	X2= 109.115 P=.0000	

Source: Author's field survey, 2005.

5.30 AIDS KNOWLEDGE AND CONDOM USE BY SEX.

Knowledge of AIDS is necessary to recognize one's behaviour as high risk and then take action to change that behaviour. Accuracy of knowledge therefore influences the degree to which persons acknowledge their behaviour as risky and types of precaution they take to reduce their risk. However, research on links, between AIDS knowledge and condom use has produced mixed results. An examination of AIDS knowledge and sexual behaviour among secondary school students and college students in Tanzania found that participants with " good" knowledge of how HIV is transmitted were unlikely to use condom despite their awareness of the increased risk for HIV infection from such behaviour (Maswanya , *et al* (1999). Conversely, among adults in a cross-sectional study in rural Senegal, persons with "good" knowledge of AIDS were more likely to use condoms than person without "good" knowledge (Langarde *et al* 2000).

TABLE 5. 19 Distribution of Respondents by AIDS knowledge and by condom use by sex.

VARIABLE	UNPROTECTED SEX		UNSTERILISED INSTRUMENT		BLOOD TRANSFUSSION	
**Age	MALE N=240	FEMALE N=163	MALE N=240	FEMALE N=163	MALE N=240	FEMALE N=163
15-24yrs	92.8	89.5	34.2	41.7	54.0	53.0

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25-34yrs	91.4	84.5	34.3	49.3	54.9	56.9
35 & Above	90.8	92.4	35.8	49.5	64.7	64.2
	P= .221	P=.110	P=.256	P=003	P=.245	P=.235
****Education**						
None	60.5	67.3	35.2	22.4	65.1	48.9
Primary	61.5	83.3	36.3	42.1	65.3	54.3
Secondary	73.4	78.2	37.8	43.3	68.7	67.5
Post Sec	84.2	74.5	38.5	52.5	71.6	68.3
	P =.000	P= .00	P=.002	P =.015	P=.023	P=.003
****Occupation**						
None	60.1	61.3	32.1	38.5	42.2	43.5
Trading	62.1	62.3	36.8	37.2	55.1	58.4
Artisans	62.2	60.2	43.4	45.5	48.9	63.3
Professionals	63.0	63.1	54.3	50.3	53.2	65.2
	P=.001	P=.004	P=.014	P=.008	P=.005	P=.007
****Place of Residence**						
Rural	60.2	59.7	52.8	51.5	48.9	52.3
Semi-urban	63.3	60.5	53.5	53.2	52.3	58.6
Urban	64.3	61.2	54.0	55.3	66.7	61.0
	P=.004	P=.000	P=.000	P=.000	P=.000	P=.002

Source: Author's field survey, 2005. ** Excluding none response Category

Table 5.20 describes knowledge of AIDS transmission among respondents by age, residence, occupation and education. Respondents were asked to identify different sources of contracting HIV/AIDS. The responses can be largely grouped into three categories: unprotected sex, unsterilised instruments and blood transfusion. Overall the table shows that the highest proportion of respondents (89%) regarded unprotected sex as the most significant mode of AIDS transmission and they used condom in the last sexual relationships. Less than half of those who mentioned blood transfusion and unsterilised instruments used condom in the last

sexual affairs. It shows that the respondents have good knowledge about mode of transmission of AIDS but prefer not to use condom during sexual intercourse.

The table shows that knowledge of AIDS transmission was significantly associated with place of residence, education and occupation. This is in line with the previous studies.

5.31 HEARD OF HIV/AIDS AND HAD SEXUAL INTERCOURSE BY SEX

It is generally acknowledged that sexual behaviour change is the most effective means of controlling the spread of HIV/AIDS in our society. Knowledge about HIV/AIDS and sexual behaviour show that 64 % of male and 48% of female respondents who have heard of HIV/AIDS had sexual intercourse in the last twelve months that preceded the survey. The result is an indication that although people have the knowledge about HIV/AIDS most of them still involve in premarital and extramarital affairs. This means that knowing is not doing among the respondents. Knowledge does not necessary bring about a change of attitude. More awareness creation is needed to drive the messages home.

Table 5.20 Distribution of Respondents by Heard of HIV/AIDS and by Had Sexual Relations.

	MALE	FEMALE	TOTAL
YES	64.6 (472)	47.8 (283)	56.3 (755)
NO	35.4 (259)	52.2 (275)	43.5 (534)
Total	100 (731)	100 (627)	100 (1358)
	X^2 P=0.532	X^2 P=0.421	

Source: Author's field survey, 2005.

5.32 VCT AND HAD SEXUAL INTERCOUSRE

Attitude to HIV testing is an indicator of willingness to establish one's serostatus, which has implications for sexual behaviour change. Table 5.21, shows that 74.8 percent of males and 64.0 of females who had sexual affairs want to have HIVAIDS test. Although this is a good indicator for the control of prevalence rate, majority of the respondents who indicated their willingness want government to do it for them freely.

5.21 Distribution of Respondents by VCT and by had sexual intercourse by sex

	MALE (N=472)	**FEMALE (N =283)**	**TOTAL (N=755)**
YES	74.8	64.0	70.6
NO	25.2	36.0	29.4
TOTAL	100.0	100.0	100.0

Source: Author's field survey, 2005.

SUMMARY

This chapter presents sexual behaviour and networking among the studied population. Despite the announcement about HIV/AIDS in Lagos State, more than two-thirds of males and half of females had intercourse with other partners apart from their spouses. It shows that there is a high sexual activity in the study area. It was also revealed from the study that 74 % of the males and 37% of females had sexual affairs with more than two partners. It implies that multiple sexual relationship still exists among the respondents. The level of risk taking by the

respondents shows that four out of every five male respondent and three out of every five female respondents had intercourse with casual partners. This can increase the prevalence level of STIs especially HIV/AIDS.

In terms of networking, the percentage of females who had their sexual affairs in another city double the male respondents, while more males had their sexual relations in the rural areas. It is one of the reasons why HIV/AIDS is now found in the rural areas. Duration of courtship between the respondents shows that most of the respondents are in the other place in which they had extramarital sex is les than twelve months.

Regarding the concurrent partners, three-quarter of male and one quarter of female respondents reported that the relationship is no longer going on between their sexual partners; eventually this can lead to increase in the sexually transmitted infections. Half of males and one-third of female had sexual relations under the influence of alcohol, which may not allow them to use condom.

With respect to their use of condom, fifty-five percent of the respondents used condom in the last sexual intercourse. On the frequency of use, more females than males indicated that they normally used condoms, this can be to prevent unwanted pregnancy from the relationships.

In terms of payment for sexual relations, sixty-eight percent of male and thirty percent of female respondents exchange gifts or money for sex always, while more females than males reported that they often receive or give gifts for sex. This shows that sexual relations have been commercialized.

Knowledge of sexually transmitted infections is universal among male and female respondents. The most widely known STIs are Syphilis, Gonorrhea, Herpes and Candidiasis. Their sources of information are through radio and television. Some of the correct symptoms of STIs mentioned by the respondents are; abdominal pain, blood urine, discharge from vaginal and penis etc.

All the same, more females than males reported that they contracted STIs in the study area. Majority of the respondents sought treatment for the STIs they contracted. Males sought treatment than females. More females sought treatment from the traditionalist. The reason may be connected with the fact that women do not want people to know about their STIs status. The cost of treatment ranges from one thousand naira and above.

On the behaviour exhibited during the sexually transmitted infection, half of the females informed their partners that they are infected, while less than half of male respondents informed their partners about their STIs status. The findings show that majority of the infected people do not disclose their status. This will increase the transmission of STIs in the areas. On what they do not to transmit, ninety –six percent, of females and fifty-six percent of males used condom, while more males than females abstain from sex.

The socio-economic characteristics of respondents revealed that place of residence age , education marital status, level of income and occupation are significantly associated with having sexual intercourse in the last twelve months. It also revealed that there is high sexual

activity in urban areas than rural areas. Eighty four percent of females and 49% of males within age group 15-24 years had sexual relations in the last twelve months. It shows high sexual activity among the young people. More females who are singles are involved in sexual activity than males and this is in conformity with the previous findings.

The relationship between condom and other variables shows that, respondents in the urban areas are likely to use condom than their counterparts in the rural areas. This can be due to accessibility and availability of condom. The use of condom increases with age and the least users are those in younger ages. The percentages of divorced women that are using condom are higher than married women since they are not into union, they must protect themselves against unwanted pregnancies.

Moreover, three out of every four male respondents who are Christians used condom while the least users are the traditionalists. Among the female respondents Muslim women are the highest users. Findings show that there is a direct relationship between age at first intercourse and condom use among the respondents. Those that initiate sex early may not likely use condom. The pattern of ever contracting STIs is not deviated from the expected pattern, more respondents in the urban centres have contracted STIs than those in the rural areas. Also majority of females who are single indicated that they have contracted STIs while 66.7% of males who are married have contracted STIs. Sixty-nine percent of males who did not have education contracted STIs while the least are those with primary education. On the efficacy of

condom, 46% of male and 63% of female respondent who used condom said they have contracted STIs. Most of those who claimed to be using condom use it regularly.

Furthermore the survey showed that knowledge of HIV/AIDS was significantly associated with place of residence, education and occupation. Sixty-four percent of male respondents and 48% females who have heard about HIV/AIDS had sexual intercourse, it is an indication that although they have the knowledge of HIV/AIDS, most of them are still involve in risk behaviour.

Majority of those who had sexual intercourse in the last twelve months preceded the survey are willing to have HIV/AIDS test. This is a good indication of their preparedness to bring down the prevalence rate.

CHAPTER SIX

MULTIVARIATE ANALYSIS

In this chapter, multivariate analyses are employed to expunge the relationship between socio-demographic characteristics , sexual behaviour , susceptibility and living with HIV/AIDS. It also focuses on the socio-economic consequences of living with HIV/AIDS and the impact on the spread of the disease in the study area. This will show the effect of the background variables on sexual behaviour of the respondents (having sexual intercourse in the last twelve months preceding the survey, the use of condom, having multiple partner, ever contracted STIs, perceived risk, knowledge about HIV/AIDS), before examining socio-economic consequence of the diseases in the study area and the relationship between other variables. Logistic regression analysis is used to assess the association between the background variables like place of residence, age of the respondents, education, income, ethnicity, religion and having extramarital sexual relationships, the use of condom and ever contracted STIs. Logistics model is used to determine the impact of some demographic variables on extramarital affairs and the risk behaviour in the study area. Ordinary least square regression analysis is further used to determine the relationship between consequences of living with HIV and other independent variables.

Model 1 shows the relationship between the characteristics of the respondents and ever had sexual intercourse in the last twelve months preceding the survey. Since the previous studies have shown that the socio-demographic characteristics will influence having extramarital and

pre-marital sexual relationships. Place of residence has been cited in the literatures as important factor determining the extramarital and premarital sexual relationships

From table 7.1 respondents in the urban areas are 1.3 times likely to have sex compared with those in the rural areas which is the reference category. Since there a lot of club houses, hotels and brothels these can aid extramarital affairs. Also, urban centres are heterogeneous in population, which allows interactions, and relationship that may lead to sexual relationship between partners. Also 98 percent of those in semi urban areas may likely have sexual intercourse with partner apart from spouse in the last twelve months preceding the survey. This shows the impact of the city on all these areas. Another effect of this is that Badagry local government lies at the boundary between Nigeria and Republic of Benin. It is the zone for smugglers and traders. Most of the people were traders may stay for long days and nights this may make them to be involved in extramarital affairs. The age pattern of the respondents shows that people in younger ages are likely to have pre-marital and extramarital affairs than those in the older ages in the study area. Those in age group 15 – 24 years and 25-34 years are 2.367 and 2.475 times more likely to have extramarital affairs than age group 45 years and above the reference category in the study areas. Steven (2004) observed that more than half of the 14, 000 people newly infected each day are under 25 years old, most of them are girls, he explained that more than two out of three newly –infected 15-24 year olds are female. A very important finding is

Table 7.1 LOGISTIC REGRESSION OF SOCIO-DEMOGRAPHIC CHARACTERISTICS AND EVER HAD SEX IN THE LAST TWELVE MONTHS PRECEEDING THE SURVEY

VARIABLES	ODD RATIO
PLACE OF RESIDENCE	
Urban	1.072
Semi-Urban	0.984
Rural	RC
AGE	
15-24 Years	2.367
25-34 Years	2.475**
35-44 Years	1.21*
45 & above	RC
Marital Status	
Single	2.43*
Married	2.23*
Divorced	1. 65*
Widow/Widower	RC
Ethnic Group	
Yoruba	0.98*
Ibo	0.87*
Hausa/Fulani	0.52**
Others	RC
Religion	
Christianity	7.647**
Islam	2.919
Traditional	RC
Income per Annum	
< N120,000	RC
N121,000-N240,000	5.410
N241 & Above	2.918
Education	
None	RC
Primary	3.587
Secondary	1.962
Post Secondary	5.030
Occupation	
None	RC
Trading	1.485**
Public\Civil Servant	1.325
Artisans	0.982*
Professionals	1.32*

RC indicates the reference category
*** Sig. at P < .05**
**** Sig. at P < .01**

that as the age of the respondents increase, there is possibility of not involving in extramarital sex. This is natural because some of them would have become grandmothers and fathers, they will want to lay a good examples for their children. While those women among them would have reached the menopause stage, which implies that they may not be sexually active. This was in support of the previous findings that most of the people involved in the premarital affairs are those in their early ages especially before age 40 years (Abanihe, 1994, Orubuloye et al 1992).

The marital status did not deviate from the expected pattern, those respondent, who are single are 2.43 times likely to have extramarital sex compared with those who are widow/widower in the study areas. This is one of the reasons while the HIV/AIDS is very rampant among the youth who are singles. They normally have multiple partners with the belief that they are not yet married. Those males believed that they can sample as many females as possible before making the choice of the right woman, while females at times did it for monetary gains Some even believed that it is part of socialization and that variety is spice of life. It was not surprising that those who are divorced are 1.3 times likely to have extramarital affairs. This can be in connection with the fact that they are not in any marital bond this may influence them to have multiple partners. Orubuloye et al (1994) in an earlier study explained that some women believed that women who have been divorced can have extramarital partners so as to train their children but it is forbidden for the married women. But most of the married respondents are 2.23 likely to have extramarital affairs in the study area. This can be the impact of urbanization

on ethnic group, 98 percent of the respondents who are Yoruba are likely to have extramarital affairs compared with others who form the reference category, while only 52 percent of the respondents who are Hausa/Fulani are likely to have extramarital sex. This can be the influence of their culture on extramarital affairs and their religion which allows having many wives as possible. Their women are normally in purdah which may make it difficult for them to get involved in extramarital affairs.

Income has been established as a factor influencing premarital and extramarital relationship, from the logistic regression, those in higher income between N121,000 –N240,000 are 5.3 times likely to involve in extra marital sexual relations in the last twelve months preceding the survey than those with the lower income, while those in N241,000 and above are 1.2 times likely to have sexual relations apart from partner. The reason for this pattern is that men in this category would have the means to attract women with lower socio-economic status especially young females.

Orubuloye et al (1994) in their studies of sexual networking in the Ekiti District of Nigeria, observed that 16 percent of rural females and 21 percent of urban females who have had premarital sex said that they did so primarily for material returns like gifts either in rural or urban areas. On the other hands those young males also involve in these extramarital relationship with women above their age for material returns. Women in the high economic status normally enticed young males with their affluence especially those women referred to as “Cash Madam”. They are the women in high government positions and in politics.

Although one would expect that religion will be a controlling factor for the extramarital affairs since the two religions are against premarital and extramarital affairs, Jeremiah (1997) believed that religion has done a lot to tame human society, that the teaching of the sixth commandment: " Thou shall not commit adultery" has positive value in reducing or controlling premarital and extramarital sexual activities. The Table shows that Christians are 7.6 times more likely to have sexual affairs apart from their partners while Muslims are 2.9 times more likely to have sexual affairs apart from their partners when compared with the reference category. This shows that religion did not have impact on extramarital sexual affairs of the respondents in the study area. This is also in conformity with the previous findings that religious inclination had no significant association with numbers of sexual partners in the past years when other factors are controlled except devoutness (Hofferth and Hayes, 1984, Dune et al 1994).

On level of education, it was revealed that respondents with post secondary education are 5.0 times likely to have sexual activities with other people apart from their partners. Surprisingly, those with secondary education are the least to have extramarital affairs. The education of the respondents did not have impact on the sexual activities. The occupation follows the pattern of education, those with good jobs especially professionals, are 1.3 times more likely to have sexual affairs with others apart from their spouse when compared with the reference category (which is those that did not have job). These are the people that are also with high income and have the means to attract females into sexual relationships.

6.2 LOGISTIC REGRESSION OF SOCIO-DEMOGRAPHIC CHARACTERISTICS AND USE OF CONDOM.

Model two shows the relationship between socio-demographic characteristics of the respondents and ever used condom in the last twelve months preceding the survey. From table 7.2, it was observed that the place of residence will influence contraceptive use, especially the use of condoms. The urban residence are 1.12 times more likely to use condom compared with the reference category, while ninety –one percent of those in the semi-urban area are likely to use condom.

With the age of the respondents the use of condom increases with the age of the respondents up to 44 years. This is in line with the previous study that the use of contraceptives increases with age. It is of interest to note that only 98 % the respondents who are between 15-24 years are likely to use condoms. This is the adolescent group. Researches show that they don't normally use condom and they are normally involved in risky behaviour. This is one of the reasons why they are one of the most affected with HIV/AIDS in the study area.

The marital status is also not deviated from the expected patterns those that are married are 4.3 times more likely to use condom when compared with the reference category. Eighty-four percent of those that are single are likely to use condom compared with the reference category. This is also in support of the previous study that majority of the youths do not use condom,

even when they are involved in the risky behaviour. Among the ethnic group, only Fifty six percent of the respondents who are Fulani/Hausa are using condom compared with the reference category while those who are Yoruba and Ibo are 1.037 and 2.085 times respectively more likely to use condom compared with the reference category i.e. the other ethnic groups. The findings show that those that are Fulani\Hausa are the least likely to use condoms. This cannot be diffused from the cultural belief and attitude of people of the Northern part of the country towards family planning and child spacing. On the issue of religion sixty-three percent of respondents who are Christians and eighty–four percent of respondents that are Muslims are likely to use condoms in the last sexual intercourse compared with the reference category, traditionalist. This implies that religion has effect on the use of condoms in the study area. There is also significant relationship between the use of condom and the religious belief of the respondents.

Table 7.2 LOGISTIC REGRESSION OF SOCIO-DEMOGRAPHIC CHARACTERISTICS AND USE OF CONDOM

VARIABLES	ODD RATIO
PLACE OF RESIDENCE	
Urban	1.123
Semi-Urban	0.915
Rural	RC
AGE	
15-24 Years	o.9871
25-34 Years	1.939
35-44 Years	1.951
45 & above	RC
Marital Status	
Single	0.843
Married	4.359**
Divorced	1. 03*
Widow/Widower	RC
Ethnic Group	
Yoruba	1.037*
Ibo	2.085*
Hausa/Fulani	0.589*
Others	RC
Religion	
Christianity	0.631
Islam	0.844
Traditional	RC
Income per Annum	
< N120,000	RC
N121,000-N240,000	4.231**
N241 & Above	1.294
Education	
None	RC
Primary	0.550
Secondary	0.223
Post Secondary	0.396
Occupation	
None	RC
Trading	1.072
Public\Civil Servant	2.367
Artisans	0.984
Professionals	1.763

RC indicates the reference category
*** Sig. at P < .05**
**** Sig. at P < .01**

However, on the income and the use of condom, respondents with income between N121, 000-N240, 000 are 4.2 times likely to use condom compared with reference category, while those with income above N241,000 are likely to use condom compared with the reference category. This shows that the higher the income the tendency to use condom in the study area. In relation to occupation public\civil servant are the highest users of condom in the last sexual intercourse compared with reference category, while only 98 percent of the respondents who are artisans are likely to use condom. These are those with little education and may not have adequate knowledge of the implications of not using condom.

The pattern of relationship between education and the use of condom did not deviate from the expected results. Fifty-five percent of the respondents with primary education are likely to use condom when compared with the reference category, while only twenty-two percent of those with secondary education are likely to use condom compared with the reference category (which are those with no education).

Table 7.3. Ordinary least square regression coefficients of accepting status and selected variables

Variables	Coefficients	T
Having Multiple sexual partners		
Yes	-0.74	-4.51
No(r)	-	-
Use Condom in the last intercourse		
Yes	-5.85	-28.32
No (r)	-	-
Ever Contracted STIs		
Yes	-4.76	-29.67
No (r)		
Perceived Risk		
Yes	-0.78*	-3.99*
No (r)	-	-

Table 7.3 displays the result of multiple regression models for the willingness to accept status by other variables like having multiple partners, the use of condom perceived risk and ever contracted STIs. From the table there is an inverse relationship between the willingness to accept the HIV/AID status and having multiple partners. Those who had sex with multiple partners indicated that they would not accept their status even when tested positively. They also perceived that they are not at risk. This will lead to increase in the rate of transmission of HIV/AIDS in the study area. This confirmed one of the formulated hypotheses that unwillingness to accept status reduces the perceived risk of infection and increases the spread of HIV/AIDS. Since they agreed that they are not at risk, most respondents may not likely used condom. This eventually shows the attitudes of people towards accepting status and the implications for the transmission of HIV/AIDS in the study area. Surprisingly, those that have

been infected with one or more STIs also don't want to accept their status even if, they are tested positive.

SUMMARY

Finding in this section have clearly established that place of residence will influence having extramarital affairs. Respondents from the urban areas are 1.3 times likely to have sex compared with those in rural areas. A very important finding is that there is inverse relationship between age and having extramarital affairs. This is natural because some of them would have been grand mothers and fathers. Income was also established as a factor fueling sexual relations. Those with higher income N121,000 – N240,000 are 5.3 times likely to involve in sexual relations apart from their spouses in the last twelve months preceding the survey.

The analysis also reveals that those with post secondary education are 5.0times likely to have sexual activities with other people apart from their partners. Education did not have impact on respondents' sexual activities.

In this study the use of contraceptives increases with age. It is of interest to note that only 98% of the respondents who are between 15-24 years are likely to sue condom in the study area. Researches have shown that they don't normally use condom and they are normally involved in risky behaviour. This is one of the reasons why the group is the most affected with

HIV/AIDS. There is a significant relationship between the use of condom and the religious belief of the respondents.

Moreover, there is an inverse relationship between the willingness to accept the HIV/AIDS status and having multiple partners. Those who had multiple partners indicated that they would not accept their status. This will lead to increase in the rate of transmission of HIV/AIDS in the study area.

CHAPTER SEVEN

SOCIAL CONCEQUENCES OF LIVING WITH HIV/AIDS

Current statistics about HIV/AIDS epidemic, as devastating as they are, do not reveal the broader social and economic impact of the disease in Nigeria. While recent scientific efforts have resulted in a series of discoveries and advances in understanding and controlling the virus that causes AIDS. This progress has had limited impact on the majority of HIV infected people and Nigerians.

The spread of HIV has been fueled by poverty, abuse, violence, prejudice and ignorance. Social and economic circumstances contribute to vulnerability to HIV infection and they intensify impact, while HIV/AIDS generates and amplifies the very conditions that enable the epidemic to thrive. Just as the virus depletes the human body of its natural defenses, it can also deplete families and communities of the assets and social structures necessary for successful prevention and provision of care and treatment for persons living with HIV/AIDS (UNDP 2001).

This chapter examines the social impact of living with the disease in the study area. It also expunges the impact of this on the transmission of the disease within study population.

7.1 SOCIO-ECONOMIC CHARACTERISTICS OF PLWHA

It is observed from studies that most people normally affected with HIV/AIDS are young people. Reports reveal that half of all new infections worldwide are among young people aged between 15-24 years. Those stricken will likely die of AIDS before they turn 35 years in the absence of treatment (UNAIDS, 2004)

From table 7.1, 11% of those infected are those who are less than 20years of age. While 66% of females and 44% of males are in age group 21-40 years. This shows that these people have been affected in the early ages before they got to know of their status. UNICEF (2002), reports that sexual activity begins in adolescence for the majority of people. In many countries, unmarried girls and boys are sexually active before the age of 15. Adolescents who start having sex early are more likely to have sex with high-risk partners or multiple partners, and less likely to use condoms. This makes the adolescents the most infected group in various parts of the world. Ten percent of male respondents who are above 60 years of age reported that they are infected with the virus. This was also in support of the recent findings that older people are increasingly being infected with HIV/AIDS, although the available data did not include how the pandemic is affecting this population group. UNAIDS (2004) reports that ten percent of all AIDS cases are persons age 50 years and above, a quarter of these are over age 60 years. Older women appear to have higher incidence rates than older men, and persons of colour are especially at risk.

Table .1 Distribution of PLWHA by Socio-Demographic Characteristics

VARIABLES	MALE (N= 61)	FEMALE (N=127)	TOTAL (N = 188)
AGE			
0-20Years	11.5	11. 1	11.2
21-40 Years	44.3	66.9	59.6
41-60 Years	34.4	22.0	26.1
61 & Above	9.8	-	3.1
Total	100.0	100.0	100.0
Marital Status			
Single	44.3	33.9	37.2
Married	45.9	55.1	52.1
Divorced	9.8	11.0	10.7
Widow/Widower	-	-	-
Total	100.0	100.0	100.0
Ethnic Group			
Yoruba	54.1	44.1	47.3
Ibo	36.1	21.3	26. 1
Hausa/Fulani /Tiv/Idoma	9.8	-	3.2
Edo/Irobo/Effik		34.6	23.4
Total	100.0	100.0	100.0
Religion			
Christianity	78.7	52.0	60.6
Islam	21.3	48.0	39.4
Total	100.0	100.0	100.0
Income per Annum			
< N50,000	78.7	59.6	62.8
N51,000-N100,000	21.3	23.5	22.8
N101 & Above	-	16.8	11.1
Total	100.0	100.0	100.0
Education			
None	-	16.5	11.2
Primary	41.0	20.5	27.1
Secondary	13.2	44.1	34.0
Post Secondary	45.8	18.9	27.7
Total	100.0	100.0	100.0
Occupation			
Unemployed	23.0	22.0	22.3
Students	11.5	11.8	11.7
Trading	21.3	36.2	31.4
Public\Civil Servant	-	7.9	5.3
Artisans	19.7	0.9	6.9
Retiree	23.0	4.7	10.7

Professionals	1.5	16.5	11.7
Total	100	100	100

But this cannot be unconnected with the extramarital affairs syndrome. Surveys conducted in different parts of the country show that majority of men and women are still involved in extramarital affairs especially unprotected sex (Abanihe, 1994; Boroffice, 1995; Owuamanam, 1995; Orubuloye, 1999, Adeyemi, 2001;)

From this study, more females are infected than males and most of the females were infected before age 40 among the sampled population. Report from Kenya shows that one girl in four between 15-19 lives with AIDS, compared with one in 25 boys in that age group. In rural Uganda, the ratio is six infected girls to every infected boy (UNIADS, 2003). Gender inequalities are a major driving force behind the AIDS epidemic. UNFPA (2002), explained that women and adolescent girls are more vulnerable to HIV/AIDS than men and boys, not only because they are biologically more susceptible to sexually transmitted infections including HIV, but because they often lack power to negotiate the terms of sexual relations or economic independence. This makes females to be more prone to infection of HIV/AIDS than men. Another reason for the difference in the ratio of male to female infected cases is due to the fact that men may want to hide their status with the fear of being stigmatized among friends and relatives since they cannot be detected by merely looking at them. Traditional practices, such as female genital cutting, early and forced marriage, or the "inheritance" of widows among brothers and other forms of sexual abuse are not only violations of human rights; they

are closely linked to one of the reasons why females are more infected with HIV/AIDS compared with men.

However, on marital status, more males than females who are single reported that they are infected, while more than half of the female respondents that are married were infected. The pattern of the distribution cannot be devoid of the fact that most of the women enter sexual coitus earlier than males, some are even involved in unprotected sex with older men for gifts and money. Some of them are forced into sexual relations at younger ages. UNFPA (2002), reports that men transmit infections more efficiently to women than vice versa. Men are eight times more likely to transmit HIV to female partners through unprotected sex than women are to transmit the virus to men. In many societies, women cannot insist on fidelity from their partners, demand condom use or refuse sex, even if they are too young for sex or know their partners are HIV-positive. This can be a substantive point why married women are more infected than men. It is of interest to note that more females who are divorced are infected since they are not under any marriage obligations. This will give them opportunity to have multiple sexual partners. Caldwell (1995) revealed that while risky sexual behaviour and HIV-infection among men is not necessarily linked to their marital status, sexual instability associated to long celibacy, to divorce and to widowhood, is thought to be a leading factor that favours HIV infections among women.

Various ethnic groups have culture and traditions which can have positive effect on the HIV/AIDS infections and transmission. Also, attitudes of each of these ethnic groups to sexual

activities determine rate of infection. From table 6.1 majority of the respondents interviewed are Yorubas. This was expected since the survey was conducted in Southwestern part of the country. Surprisingly, 34.6 % of the females who are infected are from Edo/Urhobo/Effik, this is the region or part of the country where most of their young girls are known to be involved in prostitution and female trafficking. Chigbo (2002) reported that many of the Bini girls deported are HIV carriers, out of 910 persons screened in the hospital in the past two years, 99 persons were found to be HIV positive. This figure represents more than 10 percent of the total population. This implies that out of every 10,000 persons in Edo State, at least 1, 000 will be positive. This is a great calamity if the statistics is found to be true because, most of the infected persons would have been involved in extramarital and premarital affairs and this will lead to increase in the prevalence rate not only in the state, but also in a nation. This finding was supported from interviews with two of the PLWHA who are positive and are commercial sex workers.

"I was deported in the year 2001 from Italy where I was doing prostitution. Immediately I came home I thought my parents have utilized my proceeds judiciously until I found out that they did nothing. I had to come back to Lagos to meet my friend who eventually introduced me again into the job. It was last year when I fell sick that I was confirmed HIV positive".

Urhobo lady who is a commercial sex worker.

"After finishing my secondary school and I did not pass my 'O' level examination, my friend just came home and told me to join her in Lagos to come and do business so that I can have money for my examination. On getting to Lagos, I was told that I will make my money by what I have (i.e my body) Eventually I joined her as a commercial sex worker, early this year I was confirmed positive".

These are those who came to Lagos for business or to get jobs but eventually found themselves at hotels and brothels around the city of Lagos and its environment. Caldwell (1995), reports that most girls in Southern Nigeria now have some secondary education, and many secondary school leavers feel themselves to be unsuited to the traditional occupations of farming or trading. Many regard these jobs as more degrading than selling sex in the cities, furthermore, they have a strong desire for the clothes and other possessions that go with a high-earning occupation in the city and envy the well-dressed young women who have visited the village or the rural areas.

Studies have shown that religion will influence sexual behaviour, since religion provides important ethical guidelines for living, for interpreting natural events including disasters and misfortunes, and coping with life's milestones, from birth through illness to death. They also often provide anchor in a time of rapid social change. HIV/AIDS poses new challenges to religions, because its main mode of transmission is sexual. Many religions have had ambivalent attitudes toward sexuality. The ambivalence continues today, and often creates problems for HIV/AIDS prevention and care. The epidemic is interpreted by some people as divine punishment for sexual transgressions, from premarital sex to homosexuality (Action AIDS 2000).

Using data on religion, the pattern among the respondents shows that two –thirds of the people infected are Christians. This as earlier deduced may be relation to the type of marriage practiced by these people (i.e. monogamous).

Orubuloye *et. al* (1997) explained that most of the people that are involved in extramarital affairs are those with monogamous marriage. This is a fact that cannot be ignored because of the high number of infected Christians among the PLWHA patients interviewed. On the Other hand, among the female respondents Muslim, are more infected than their counterparts who are Christians. It is also connected with the type of marriage. Since most of the Muslim women are in polyganous marriage, they may not have regular access to their husbands and sexual activities with their husbands are rotated among the wives. This may compels the woman to look for extramarital partners who may have been infected with HIV virus.

All the same, most women living with HIV as well as those at highest risk for HIV infection are poor and members of a minority group. They suffer violence throughout their lives that is beyond what women of higher socioeconomic status generally experience. The struggle to survive everyday overshadows attention and concern about a virus that does not demonstrate any immediate harmful threat until it has a visible presence manifested by illness and death.

From table 7.1, three out of every five infected with HIV are earning between o-N50, 000 per annum which is the UN standard. This shows that the disease is more prominent among the poor in the study area. Ironically, more males than females are living below this income status, while 16.8% of the female infected are earning above N100, 000. This shows that the disease is also present among the high socioeconomic status of the population. Economic status determines people's access to health facilities. There is also a possibility for those with high socio economic status to have access to the antiretroviral drugs than their counterparts with low

economic status. Freudenthal (2001), reports that women are more vulnerable to HIV/AIDS because they have less secure employment, lower income (if any), less access to healthcare and social security, less entitlement to assets and savings and little power to negotiate sex. They are more likely to be poorly educated and have less access to land and credit facilities than men.

From this survey, the number of female respondents infected increase with the level of education up to secondary school before it starts to decline, whereas for males those with post secondary education are the highest infected with HIV. The pattern shows that there is a positive relationship between education and being infected up to the secondary school among the sampled population. Adegbola and Oni (1995), also report that those without education are likely to have less extramarital affairs compared with those with secondary and post secondary education, and this has great implications for HIV/AIDS infections. Similarly, those with higher education, constitute the social and government elite whose work experiences are more likely to expose them to high risks of extramarital overtures and there is a tendency to have extramarital relationships with infected partners. Conversely primary school educated men include large number of merchants, entrepreneurs and skilled and semi-skilled workers, many of whom are considered wealthy by Nigerian standards, and therefore can afford the cash which many extramarital partners demand (Abanihe 1994). UNDP (2001) also reported that HIV infection is high among those who are better educated and highly trained. The epidemic is thus bi-modal in its distribution with peaks in both the poorest segments of the population, but also amongst the richest and best educated.

Occupation of the respondents followed the education pattern, majority of the male respondents infected were unemployed and retirees. Although this will make the infection to have a great impact on their lives since they will not be able to afford the necessary treatment. Some of the respondents interviewed decided to resign their jobs and relocate because of the stigma and discrimination. This is what a discussant who is a female banker has to say

When I was sick and admitted in the bank's hospital, I was confirmed HIV positive. This was revealed to my manager which later becomes news in my place of work. Although they did not sack me. People started avoiding me and I felt ashamed. I informed my husband who is also infected and he asked me to resign and join him in his business".

Also, trading is another occupation that is common among the infected respondents. As trading involves traveling out of places of usual domain, there is the tendency for traders to be involved in risky behaviours.

7.2 HISTORY OF HIV/AIDS INFECTION AMONG PLWHA

The hysteria surrounding AIDS infection makes people not to seek expert medical care and advice until they are already sick. From table 6.2 most of the respondents found out about their seropositive status at health facilities like, clinics or centres when they were sick and when they had Tuberculosis. While women discovered their status during the childbirth and

pregnancy, few of the respondents revealed that they discovered about their status during test. The implication of this is that some of the infected persons may have been involved in the risk behaviour that can make the virus to be transmitted to other people. Majority of the respondents did not visit the health facilities until they discovered one of the symptoms of HIV/AIDS. These are some of the excerpts from the respondents on how they got to know of their status:

A female respondent

When my six –months old baby felt sick, we took her to the hospital but she eventually died, it was during the test they did for her that they discovered that she was positive. I then went for the similar test and I was confirmed positive, but my husband was negative.

An Ibo woman

My husband felt sick and the ailment was so severe that we took him to the village to see native doctor but he eventually died. After few months of mourning, I started feeling the same way as my husband (rashes on my body, sore in my tongue) and my sister took me to the hospital. They did the test for me and it was positive. It was then I knew that my husband died of the disease.

Another discussant (male)

I was sick and later had TB. It was during the test that they discovered that I was positive.

A young lady:

I fell sick and I thought it was typhoid and later I discovered that I was losing weight, people stated getting suspicious about me, until my boss advised me to go for HIV/AIDS test and it was positive

From the FGD, and In-depth interview, it is obvious that some of the respondents that are positive have been treated for TB before they were confirmed to be positive. Previous studies have shown that TB is the most common infection among and leading killer of people with HIV/AIDS. Of the estimated Africans now living with HIV, about 8 million also harbour the bacillus that causes TB. Each year, 5 to 10 percent of these 8 million develop active TB, and up to 4 million will develop the disease at some point in their lives. (WHO 2003).

On the type of the virus had; majority of the respondents had HIV –1 which is the commonest in every part of the world. This type of virus is transmitted about three times more readily than HIV-2, which also causes AIDS and has been seen mainly in West Africa and Mozambique (UNICEF, 2002). This can be one of the factors for differences in the median time from infection to development of AIDS between the industrialized countries and sub-Saharan Africa countries.

The reactions of people living with HIV/AIDS when they heard that they are positive were sought. Some of the respondents felt very bad, some thought of committing suicide, while others cried and fainted. The various reactions explained by the PLWHA was due to the hysteria surrounding AIDS infection and its associated stigmatization usually create a sense of panic and fear. Because the disease does not have any known cure, infected persons react negatively with shock when they heard about their seropositive status. Some are worried about their children, wife, husband and the extended family and the thought of what will becomes of

them, especially when their bread winners are no more causes great concerns. This is one of the social impacts of living with the disease. These are the exert from the interview:

A male respondent:

I was shocked, went home and started preparing for my death. Various thoughts came to my mind; who will take care of my children, what about my wife and my aged parents. For days I could not come out thinking that death will come immediately.

A female (single) respondent:

I fainted when I heard that I was positive and after I was resuscitated I vowed to transmit the disease to others since I was infected by a man but later, my sister told me about SWAAN and I joined the support group. It was then I learnt not to transmit the disease but fight it. Later I joined the voluntary counseling that fight against HIV/AIDS.

However, in terms of proportion, more females thought of committing suicide and were more devastated than males. These reactions may be related to some of the popular views about the disease, such that "it is a disease which affects "immoral" people and that it has no cure (Awusabo-Asare, 1999)

TABLE. .2 HIV/AIDS History of PLWHA

VARIABLES	**MALE**	**FEMALE**
How did you get to know of your status?		
I had Tuberculosis	+	+
When I was Sick	+	+ +
During child birth	-	+
By doing HIV/AIDS Test	+	+
Types of Virus Had?		
HIV 1	+ +	+ +
HIV 2	+	+

HIV 1 &2		+
How did you feel?		
I felt Bad	+ +	+ +
I thought of committing Suicide	+	+ +
I cried and devastated	+	+
I fainted	+	+

Note ++ opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half).
- opinion was not expressed at all.

TREATMENT SEEKING BEHAVIOUR FOR STIs AMONG PLWHA

Over 100 million new sexually transmitted Infections (STIs), excluding HIV, occur each year among young people under 25 years of age. STIs greatly facilitate HIV transmission between sexual partners if one partner is infected and not treated. So treating and preventing them is an important step in breaking the HIV/AIDS chain (UNICEF 2002). From table 7.3, it is clear that most of the PLWHA interviewed have had STIs before discovering their seropositive status. It indicates that there is a tendency for most of the people infected with STIs to develop to HIV/AIDS. A study in South Africa showed that men infected with HSV-2 (herpes simplex virus-type 2) were seven times more likely to be HIV positive than sexually active men who did not have HSV-2. Another study in Mwanza, United Republic of Tanzania, showed that HIV incidence was 40 percent lower after two years in communities where symptomatic STIs were better managed than in communities lacking good STI Care (WHO, 2003). Some of the common STIs mentioned by the respondent are gonorrhea, syphilis, and herpes. STIs spread rapidly because the majority of infections either do not produce any symptoms or signs,

especially in females, or produce symptoms so mild that they are often disregarded. Respondents were asked if they seek treatment, majority of the respondents sought treatment from the health facilities and traditional medicines. Some of the respondents revealed that those STI symptoms disappeared over time after little treatment, creating the false impression that the diseases too have disappeared. This shows that many of the respondents do not know the difference between normal and abnormal conditions and therefore do not know when to seek medical care. These are some of the responses.

An illiterate male discussant:

"Nigbati mo ni arun gbajumo mofi lo ore mi . Osi mu mi lo si odo awon Oloogun ibile won si fun mi ni ogun . Lehin Igba die Olo Sugbo otun padawa. Kin to wa losi ile iwosan fun itoju nigbati mi o fe gbadun mo

When I had gonorrhea, I told a friend of mine and he took me to a native doctor who gave me medicine. After a while, I was relieved but the symptoms resurfaced. It was then I went to the Hospital for treatment before I was later confirmed positive.

A female discussant

When I noticed some smelling discharge I consulted a doctor who gave me some drugs and it disappeared before I was later tested positive.

Some of the respondents did not visit the right medical facilities; they prefer native doctors believing that they are good in the treatment of the STIs than the medical doctors. This can complicate the issues and eventually lead to HIV since most of these STIs are contracted through multiple sexual partners. Malungo (1999) explained that health problems from STDs tend to be more severe and more frequent in women because times women do not have

symptoms and they may have delay getting care. Some of the respondents did not even seek treatment for the STIs and this may eventually lead to HIV.

Study confirms that people who are infected with STIs are more likely to get HIV if exposed to it through sexual contact and also are more likely to transmit HIV (Wasserheit, 1992). Reasons given by respondents for not visiting the health facilities is the stigma attached to it that it can only be contracted through immoral acts. This debars some of them from visiting the clinic even when they already knew that they are infected. Malungo (1999), reports that many young people do not seek medical care because they fear that their privacy will not be respected. They may be too embarrassed or feel guilty to seek treatment. Service may also be inaccessible because clinics may be far away from them. Also, health providers may be reluctant to serve adolescents, when the services are located in maternal and child health centres, they are unlikely to be used by young men. All these factors can make the young people not to seek medical care when they are infected with STIs and this will lead to the increase in the transmission of STIs in the area.

Table 7.3 Distribution of Respondents by Treatment Seeking Behaviour of STIs

VARIABLES	**MALE**	**FEMALE**
Ever contracted STIs		
Yes	+ +	+ +
No	-	+
If yes Which STIs		
Gonorrhea	++	+
Syphilis	+	+
Herpes	+	+
Did you Seek		

treatment		
Yes	+	+ +
No	+	+
Where did you seek Treatment?		
Government Hospital	+	++
Private Hospital	+	+
Traditional Doctors	+	+
Chemist	+	

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

SEXUAL BEHAVIOUR OF PLWHA

Sexual behaviour of people living with HIV/AIDS is of considerable importance for limiting the spread of the disease and especially the nature of post-diagnosed sexual behaviour of seropositive patients. This is the period when infected persons need counseling, not only to keep them fit, but also to avoid further transmission of the disease through sex or other means. In a country where counseling of patients is not well developed, knowing the attitudes and behaviour of diagnosed patients towards their condition and to others is important for the development of intervention programme and to assist the patients to lead healthier lives

(Awusabo-Asare, 1999). The sexual behaviour of the HIV-seropositive patient was explored. From table 7.4, most of the female respondents indicated that they are still having sexual intercourse after the diagnoses, while some of the male respondents reported that they are still having sex after post diagnoses.

Majority of those who reveled that they are having or they had sexual intercourse did with their husband/wife. It was a surprise to hear that after diagnoses some of the seropositive patients still have sexual intercourse with multiple partners. The reasons given for these sexual behaviour varied from respondent to respondent. Few of them said they felt strongly that they should 'revenge' by infecting other people since they were by some people. The commercial sex workers indicated that since selling sex is only means by which they can survive, there is nothing they can do than to continue until death will come. This shows how this disease is spreading in the study area and in the nation as a whole. These are exerts from the interview:

A commercial Sex worker

"*I was confirmed positive few months ago and since I don't have any means to survive I had to continue with my business. Until they came to us at Iddo that if we are tested positive we should come to this place for counseling and advice and that is why I am here today."*

A male respondent

"*Although I am a womanizer, the case got worst when my wife traveled out of the country and when I was confirmed positive I promised to revenge on women since I contracted the virus from one of those ladies I had fun with. Although I have stopped after receiving counseling from this place*"

All the same, some of the respondents reported that the reason why they continued was that they did not believe that they had the virus when tested in the first instance. Denial is part of the syndrome associated with the disease. Their denial and unprotected sex had put some other people at the risk of infection, with some reporting being involved in sex for money.

Those who had sex said they protect themselves against transmitting it to other partners by using condom, while few did not, before they received the counseling

TABLE 7.4 SEXUAL BEHAVIOUR OF PLWHA

VARIABLES	**MALE**	**FEMALE**
After diagnosed did you continue to have sexual intercourse?		
Yes	+	++
No	++	+
With Whom?		
Wife	+	-
Husband	-	++
Sexual partner	-	+
Are you still maintaining multiple sexual partner?		
Yes	-	+
No	++	++
IF yes what did you do?		
Use Condom		+

What is your Attitude towards Condom		
Negative	+	+
Positive	+	+ +
Indifferent	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

7.5 Circumcision and HIV/AIDS

Studies have shown that circumcision will reduce the risk of being infected especially male circumcision (Caldwell and Caldwell, 1993; Hunter, 1995; Caldwell *et.al* and Orubuloye, 1999b). From table 6.5, most of the respondents interviewed were circumcised especially males. This is contradictory to the earlier finding that male circumcision will reduce the risk of infections in sub-Saharan Africa. The evidence that male circumcision will reduce HIV/AIDS is not strong enough to make it a policy in the fight against, AIDS. Recent evidence from a study in Uganda revealed that while no circumcised men in a test group got infected after having sex with HIV positive women, nearly 175 who were not circumcised got infected (Arendse, 2004).

TABLE 7.5 CIRCUMCISION AND HIV/AIDS

VARIABLES	**MALE**	**FEMALE**
Are you Circumcised		
Yes	+ +	+ +
No	+	+

Note + + opinion expressed by most of the respondents (above half).
+ opinion expressed by some of the respondents (below half).
- opinion not expressed at all.

7.6 **REACTIONS OF FRIENDS AND RELATIVES TO PLWHA STATUS**

Testing positive for HIV will have a profound impact on ones close personal relationships such as friends, family and sexual partners. One of the most difficult issues normally faced by PLWHA is how or who to inform about their status for the fear of discrimination due to the common attributes associated with the disease. Herek, (1999) explained that HIV/AIDS shared four common attributes; first, people infected with HIV/AIDS are often blamed for their condition and many people believe HIV could be avoided if individuals made better decision. Second, although HIV is treatable, it is nevertheless a progressive, incurable disease (Stoddard, 1994). Third, HIV transmission is poorly understood by some people in the general population, causing them to feel threatened by the mere presence of the disease. Finally, although asymptomatic HIV infection can often be concealed, the symptoms of HIV-related illness cannot. HIV – related symptoms may be considered repulsive, ugly, and disruptive to social interaction. The respondents were asked if they have disclosed their HIV status to any body. Majority of the respondents have disclosed their status to at least one person among their families and friends. Although some of them said it took them time before they could disclose their status, for the fear of being stigmatized or ostracized from the family. Some of the respondents are yet to disclose their status to any body based on the same reasons. Those who disclosed their status did so to their wives, husbands, and friends. More female respondents revealed their status to their families. The respondents indicated that their families and friends reacted too badly when they were informed of their status. Indeed, some of the relatives and friends abandoned them on hearing that they are positive.

Outlook, (2001) revealed that stigma harms, it can lead to feelings of shame, depression, withdrawal, worthlessness and guilt. It silences individuals and communities, saps their strength and increases their vulnerability. It isolates people and deprives them of care and support, thereby worsening the impact of infection. Some of the responses corroborated this view point.

A married woman

When we informed one of my husband's friends that we are infected with HIV/AIDS, he informed other friends and they deserted us. Even on some occasions they were avoiding us. Eventually we relocated and we don't visit them again except our church members and few members of our family that show concern.

A male respondent who did not disclose his identity.

"Eniyan leniyan a ma je. Ti aye ba fi mo asiri re won a maa fi bu o won atun fio se eleya"

Human beings will always behave as human beings. If they know your shortcomings they will use it to abuse you and make jest of you.

A male PABA

Although I did not have the knowledge as I have it now when I was told about my sister's status by my elder brother we deserted her and abandoned her to her husband. She eventually died.

Awusabo-Asare (1999), reported that the "safety net" once offered by the corporate clan to its members appears to be undergoing changes; it does not seem to provide the individual with the

protection and support it once gave. Some of them withdraw physically or emotionally from the patient because they do not want to be associated with him or her.

All the same, the respondents were asked whether they informed their children about their HIV status, most of the respondents did not inform their children about their status, while some informed then to guide them against being infected. About the reactions of those children when they heard of the status majority of them felt bad, while others were crying. This shows that children are also aware of the danger of living with the disease knowing that if not properly managed, they will soon become an orphan. Those who did not inform their children believed that their children are still young, while others believe that if they inform them, it will become news in the community. Some believe, especially those above 60 years, that they can be abandoned by their children if they get to know of their status. Some of the issues are indicated below.

A female discussant:

My children are too young. They will not understand what I am saying. They can even inform our neighbours without knowing the implications

Another discussant

When I noticed my daughter's behaviour and I knew if she was not educated about HIV/AIDS, she can get infected. She was shocked to hear that I am positive thinking that I am going to die the following day. Now she has changed and discussed with others about HIV/AIDS

In many cultures in Nigeria, families are the primary caregivers to sick member. There is clear evidence of the importance of the role that the family plays in providing support and care for

people living with HIV/AIDS. However, not all family responses are positive, infected members can find themselves stigmatized within the home.

In relation to the attitudes of families to the HIV status of the infected people, people affected by AIDS (PABA) were also interviewed about how they heard of their relative status, and their reactions. From table 7.8 majority of the respondent were told by PLWHA, while some of the respondents indicated that they were present at the health facility where the HIV statuses of their relatives were disclosed. On whether they were counseled before they were nearly all the respondents did not receive any counsel before the HIV status was revealed to them. It is of important to educate or counsel relatives of people living with HIV/AIDS before

disclosing the HIV status. This will help them and the people infected. It will also remove the stigma with the society. The responses to reaction of PABA when they heard of their relatives status were varied these include felt bad, surprise, don't believe it, and 'wept when they heard the news'

A male discussant (PABA)

"I was shocked when our doctor told me that my wife was positive and I was negative. I could not believe it . I thought I was dreaming that I will soon wake up"

Table 7.6. Reactions of Friends and Relatives to HIV/AIDS Status of PLWHA

VARIABLES	MALE	FEMALE
Have you told anybody?		
Yes	+ +	+ +
No	+	+
If yes, who?		
Family	+	+ +
Friends	+	+
Wife /Husband	+	+
Religious Leader	+	+
If No Why?		
Stigma	+	+
Discrimination	-	+
Fear of unknown	-	+
If yes, what was their reaction?		
Consoled me	+	+
Felt Dejected	+	+ +
Abandoned me	+	+
Felt Bad	+ +	+ +
Did you discuss your HIV/AIDS status with your Children?		
Yes	+	+
No	+ +	+ +
If yes, what was their reactions		
Crying	+	+

Felt Bad	+	+ +
If no, why?		
They are still Young	+	+
They will inform other people.	+	+
They will abandon me	+	+

Note ++ opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

The stigma and devaluation of identity associated with HIV, do not occur naturally, rather, they are created by individuals and communities. . HIV-related stigma manifests itself in various ways. HIV-positive individuals, their loved ones, and even their caregivers, are often subjected to rejection by their social circles and communities when they need support. They may be forced out of their homes, lose their jobs, or be subjected to violent assault. For these reasons, HIV-related stigma must be recognized and addressed as a life-altering phenomenon. People living with HIV/AIDS were asked some questions about the attitudes of their neighbours and communities towards them.

Table 7.7 Reactions of PABA to PLWHA Status

VARIABLES	**MALE**	**FEMALE**
How did you know of your relative status		
She/he informed me	+ +	+ +
We are together when they broke the news	+	+
From the health facilities	+	+
Were you counseled before you were told ?	+	+
Yes	-	-
No	+ +	+ +
Who else in your family aware of that your relation status		
Father	+	+

Mother	+	+
Brother	+	+
Sister	+	+
What was your reaction when you heard the news?		
Surprise	+	+
I wept	+	+
I felt bad	+	+
I did not believe it		+

Note + + opinion expressed by most of the respondents (above half).
+ opinion expressed by some of the respondents (below half).
- opinion not expressed at all.

Majority of the respondents indicated that their communities were not aware of their HIV status, while some women reported that they were aware of their status. On how they got to know of their status, some said when they fell sick, while others reported that they new through the health facilities. On the reactions of the community members to the PLWHA, respondents indicated that their attitude was hostile to them. These are some of their responses.

A widow

When they found out that I was positive, the community and my husband's family sent me away from my husband's house and they told me that I was the one that killed my husband. They did not allow me to take my properties. It was then I was introduced to this organisation who took care of me.

A married woman (PABA)

It was my co-tenant that got the information from her friend who is a nurse that my son, who is just 12 years old, is infected. Other people in the house started to avoid us and eventually the landlord asked us to leave his house and we relocated to Surulere

PLWHA have been stigmatized and there is tendency to hide their HIV/AIDS identity in their new locations. Others who are infected would not want to disclose their HIV status and this has a great implication for the spread and control of HIV/AIDS in the study area. UNAIDS (2004), reports that the forms of stigma and discrimination faced by people with HIV/AIDS are

multiple and complex, with the most burden on women. Researches conducted in India and Uganda show that women with HIV/AIDS are doubly stigmatized as people living with HIV/AIDS and as women. Some of these women are normally sent away by the families, after the death of the husband and they are denied their properties, which now makes the woman to depend on her children for survival. UNAIDS (2003), reports that stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics, while the societal rejection of certain social groups (e.g. homosexual, sex workers) may predate HIV/AIDS. By blaming certain individuals or groups, society can exclude itself from the responsibility of caring for and looking after such population. However, some of the PABA expressed concerns that HIV/AIDS are believed to bring shame upon the family or community which if heard publicly such community or family can be forced to move out of town. The opinion expressed supported by one of the PABA in the FGD.

A lady from Benue,

"If you are from the royal family or some families in my town they should not hear such things in your family. It is a taboo, the whole family can be castigated and sent out of the town"

Table 7.8 Attitude of the Community or Neighborhood to PLWHA

VARIABLES	**MALE**	**FEMALE**
Do people in your neighborhood know your HIV Status?		
Yes	-	+
No	+ +	+ +
Not Aware	+	+
If Yes, How?		
Through my neighbor	-	+
Through Health	-	+

centres		

Note ++ opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

7.7 ATTITUDES OF HEALTH WORKERS TO PLWHA AND PABA

Many reports reveal the extent to which people are stigmatized and discriminated against by health workers. Many studies reveal the reality of withheld treatment, non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines (Health System Trust 2004 and UNFPA 2003). These are some of the problems faced by the people living with HIV/AIDS and the people affected by AIDS. A survey conducted in 2002 among some 1,000 physicians, nurses and midwives in four Nigerian States, returned disturbing findings. One in 10 doctors and nurses admitted having refused to care for an HIV/AIDS patient or had denied HIV/AIDS patients admission to a hospital. Almost 40% thought a person's appearance betrayed his or her HIV-positive status, and 20%felt that people living with HIV/AIDS had behaved immorally and deserved their fate. One factor-fuelling stigma among doctors and nurses is the fear of exposure to HIV as a result of lack of protective equipment. Also at play, it appears was the frustration of not having medicines for treating HIV/AIDS patients, who therefore were seen as 'doomed' to die (UNAIDS 2003).

It was revealed by PLWHA that the health workers did not have the right attitudes to the people living with HIV/AIDS, most of the women that detected theirs in the hospitals during child birth reported that they were neglected on the bed in the hospital, while some were ostracized. This shows the level of discrimination against PLWHA. Although some of the motives behind being separated from others is to avoid being infected by others, but this must be done in a friendly way. The reactions of these health workers were too harsh at times with the negative attitudes to the families and relatives of infected person. This attitude can discourage people in giving care and support to those that are infected. The responses below are in support of the above assertion.

A married woman (PLWHA)

"During the birth of my last, baby I was tested positive. The doctors and nurses separated my bed and they did not want to touch the baby. Even during the ward round, they will not come and see the baby, until my husband asked them to discharge us."

A female (PABA)

"Last week we were in the hospital to visit one of our relatives who was infected. The nurse on duty shouted on us and told us that the case of the person we were looking for is different and we can not move closer to her. It was then that we told her that we knew already that the person was HIV/AIDS positive. If not they would not have allowed us to see the patient."

In some hospitals, signs have been placed near people living with HIV/AIDS and with words such as 'HIV-positive' and 'AIDS' written on them which even make them to be known to those who are in the hospital and those who came on visit. This will make people to run away from them and even possibly stigmatize them in the hospital.

Table 7.9 Attitudes of Health Workers to PLWHA AND BAPA

VARIABLES	MALE	FEMALE
What is the attitude of Health workers to PLWHA?		
Neglect on the bed	+ +	+ +
Ostracized from others	+	+
Discrimination	+	+
What is the attitude of health workers to PABA?	+	+
Ridicule	**+ +**	**+ +**
Stigmatization	+	+
Non-chalant attitude	+	+

Note + +where the opinion was expressed by most of the respondents (above half)
+ where the opinion was expressed by some of the respondents (below half)
- where the opinion was not expressed at all.

7.8 PEOPLE'S ATTITUDES TOWARD PLWHA

In other to determine the extent of discriminations among the general populace, some questions were asked about whether they can, eat together with PLWHA, hug PLWHA. e.t.c. From table 7.10, more females than males indicated they can do something like eating together, sleep on the same bed, shake hands, hug and share the same toilet with PLWHA. Although majority of the respondents indicated that they cannot do all these together with PLWHA. This shows the extent of discrimination against the people infected with HIV/AIDS. On the issue whether the PLWHA should have children, majority of the respondents said 'no'. This could be connected with the fact that people do not want the responsibility of those children. Since there is still the believe that there is no drug to care for the disease and the person infected will still die. This was also corroborated by the response of one of the PABA interviewed.

Sixty years-old male discussant

"There is no need to have children since they will not be able to take care of the children. The economic condition of the country does not even allow the extended families to take care or add additional children to the ones we have already. unless in a situation that cannot be avoided "

Other people believed that they should not have children because those children could also be infected if there is no good medical care and since most of the couples infected could not afford the cost of the fertility drug that will stabilize the viral load.

On the issues of whether the PLWHA should hold public offices majority of the people revealed that they should not. Although the reasons were not asked but it

may not be unconnected with the stigma and discrimination attached to the disease. It implies that people will not want to associate with those that are infected even if they hold public offices.

Table 7. 10. Peoples Attitudes Towards PLWHA

VARIABLE	MALE	FEMALE
****Can you do the following with PLWA?**		
Eat Together	30.9 (226)	42.4 (258)
Sleep Together	33.0 (241)	42.5 (259)
Shake hands	34.7 (254)	44.2 (269)
Hug each other	31.7 (232)	41.1 (250)
Share the same toilet	44.6 (326)	55.2 (336)
Play together	44.6 (326)	55.1 (332)
*** If no, why?**		
I don't want to be infected	69.4 (468)	49.9 (223)
I cannot stay with them	30.6(206)	26.8 (120)
No reason	-	23.3 (104)
Total	100 (674)	100 (447)
***Do you think PLWA**		

should have children?		
Yes	23.5 (172)	6.6 (40)
No	76.5 (559)	93.4 (570)
Total	100 (731)	100 (610)
*** If no why**		
They would not be able to take care of them	62.6 (350)	41.3 (245)
Their children will be infected	37.4 (209)	58.7 (335)
Total	(559) 100	(570) 100
***Do you think PLWA should hold public offices?**		
Yes	36.9 (270)	19.5 (119)
No	63.1 (461)	80.5 (490)
Total	100.0 (731)	100 (603)

Note ** Multiple responses are allowed

- Non-responses are excluded.

7.9 Attitudes of PABA Towards Alternative Treatment of the Infected Person

People with HIV/AIDS and their families normally become frustrated with management of the disease. Therefore, they are willingly look for alternative treatment with the hope of staying healthy and living longer since there is no medical solution to the disease. They have forgotten that HIV/AIDS is not a traditional illness and so far there is no hard evidence to believe that traditional medicines can treat HIV and cure AIDS, nevertheless, certain traditional medicines may be helpful in treating many of the symptoms of opportunistic infections that are part of AIDS, while others may do more harm than good. They are expensive and therefore reduce money for buying food, and they may require the avoidance of certain foods (Piwoz and Preble, 2000).

People affected by HIV/AIDS were asked if they took the infected persons to traditional doctors for alternative medicine. Most of the respondents revealed that they took the infected person for alternative medicine since they have tried the medical hospital and there is no cure for the disease. Some even explained that initially they did not know that it was HIV/AIDS they thought it was a spiritual problem until they were told in the hospital. The fake proclamation of some of the traditional healers who claimed to have cure to this disease also allowed these people to fall in the hands of these traditional healers and money is being extorted from them without the provision of any solution to the problem. These are some of the experiences of PABA about the alternative medicine;

A married woman:

When my sister fell sick, I thought it was a spiritual problem. One of my friends, now introduced me to one Baba that he would cure the ailment. After collecting a lot of money my brother now asked us to take her to the hospital before the confirmation that she was HIV-positive. We were told that it can be managed but there is no cure for it yet.

Another educated woman:

I know that my husband was positive but we thought there could be solution to it by using traditional medicines, but after visiting some of the traditional healers and there were no changes, we returned back to the hospital where he was placed on ARV

Most of the respondents also believed in the spiritual healing. They have the opinion that God is the creation of heaven and earth and He has every thing in his hand. God can heal anybody with infirmity. Some of them also quoted some healing verses in the Bible (Isaiah 33: 24,Ps 107: 19). They reported that they had visited so many churches and mosques for spiritual healing but all their efforts are fruitless. In searching for the alternative medicine for

HIV/AIDS many of the infected person will not used their drugs, with the hope of believing God for supernatural healing. This may aggravate the severity of the illness.

Table 7.11. Attitudes of PABA Towards Alternative Treatment of PLWHA

VARIABLES	MALE	FEMALE
Ever taking him/her for alternative traditional treatment		
Yes	+ +	+ +
No	+	+
Ever taking him /her to religion institution for treatment		
Yes	+ +	+ +
No	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

SUMMARY

It was observed that HIV/AIDS cut across all socio-economic groups. It can affect people of different ages and sex. It was also revealed that HIV/AIDS affects females more than males in the study area. Majority of those affected are young adults who are in the economically active group. This has a major effect for the future labour force pattern and productivity in the economy if not adequately checked now.

The unfortunate thing is that older people above sixty years of age accounted for ten percent of those infected among the male respondents. This shows that the grandparents who children of the infected person will want to rely on, are also affected. This will increase the number of vulnerable children and orphans in our society. It will also increase the incidence of child labour in the society. These children will also be vulnerable to HIV/AIDS, especially those young girls among them.

It was discovered that prostitution and female trafficking is one of the factors in the spread of HIV/AIDS in the study area. Some of the respondents infected are commercial sex workers and those who are deported from abroad. This will increase the prevalence rate in the country. It was also established in this survey that poverty is one of the factors that influence the spread of the disease in the study area. Majority of the people infected earn less than N120,000 per annum. While few women above average income were also infected these were those with higher education which constitutes the social and government elite

All the same, one of the findings was that most of the respondents did not go for test until they see one or two of the opportunistic infections like TB and Candidiasis

Some of the respondents, because of their unbelief in their seropositive status continue with their risk sexual behaviour. This makes it possible for the spread of the disease in the study area. Evidence from the survey also shows that male circumcision is not a strong factor to reduce the transmission of the HIV/AIDS in the study area. It was observed in the survey that

stigma and the fear of discrimination will not allow the respondents to declare their HIV/AIDS status to their relatives and family.

The family and communities also complicated the issues by stigmatizing the person and atimes discriminating against them. The level of stigmatization and discrimination were disclosed when the general public were asked some questions on whether they can eat, play together with infected persons etc. Majority of the respondents (two-thirds) responded that they cannot do all these with them. Some of the respondents also did not disclose their status to anybody because of the discrimination. Only few of the respondents informed their children about their status, hoping that they are too young to know that, while those who have informed them did so to educate their wards against getting infected. It was also revealed in the study that the medical officers that are supposed to give care and support to the people infected also join in stigmatizing them.

CHAPER EIGHT

ECONOMIC CONSEQUENCES OF LIVING WITH HIV/AIDS

The toll of HIV/AIDS can be severe. Although no part of the population is unaffected by HIV, it is often the poorest that are the most vulnerable to HIV/AIDS and on whom the consequences are most severe. In many cases, the presence of AIDS means the household will dissolve, as parent die and children are sent to relatives for care and upbringing. This chapter focuses on the economic implications of living with HIV/AIDS within the household system and the impact on the society at large.

8.1 IMPACT OF HIV/AIDS ON HOUSEHOLD INCOME

The PLWHA were asked about the impact of the HIV/AIDS on their income. As shown in Table 8.1, majority of the respondents indicated that the disease has affected their income, in terms of money spent on drugs with little or nothing left for food and clothing. Some even mentioned that their income is not enough to buy the ARV drugs, while some pointed out that they have sold part of their properties in order to pay for the medical bills. This has confirmed the hypothesis that those living with HIV/AIDS may likely spend more of their income on health care than those without HIV/AIDS. This assertion was also supported by the responses of discussants from focus group discussions:

A 35 years old woman:

"The diseases has a great impact on the household income, the drugs are expensive and unaffordable. In some cases will need to borrow money to buy these drugs, since will cannot fold our hand and allow him to die gradually"

A widow

The disease is like a devourer ones you have it you can hardly meet up again. The experience with my husband has shown that there is no amount of money that you can have, you will still feel the impact on your finances.

The people affected by AIDS (PABA) were also asked about the impact of the disease on their income. Most of the respondents pointed that they had spent most of their money on ARV drugs and medical bills. Some even complained that, the disease is affecting their business, since they have to take care of the infected persons. Taking care of a person with AIDS is not only an emotional strain for household members, but also a major strain on household resources and income. It reduced ability of the care-givers to work, mounting medical fees and push affected households into deeper poverty. According to a study in Cote d' Ivoire, health care expenses rose up to 400% when a family member had HIV/AIDS (UNAIDS, 2005) . It is estimated that in Burkina Faso, 20% of rural families have reduced their agricultural work or even abandoned their farms because of AIDS. In Ethiopia, AIDS-affected households were found to spend 11-16 hours per week performing agricultural work, compared with an average 33 hours for non-AIDS affected households (UNIADS, 2004). These are some of the impacts of the disease on the household income and resources.

TABLE 8.1 IMPACT OF HIV/AIDS ON HOUSEHOLD INCOME

VARIABLES	MALE	FEMALE
Did HIV/AIDS affect your income?		
Yes	+ +	+ +
No	+	+
If yes, how?		
Increase medical bill	++	+ +
No savings	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

8.2 COST AND TYPE OF TREATMENT RECEIVED BY PLWHA

When HIV was first identified in the early 1980s, there were no drugs to treat the virus and few treatments for the opportunistic infections associated with it. Since then, a number of medications have been developed to treat both HIV/AIDS and opportunistic infections. For many people, newer treatments have both extended and improved the quality of life, but none of these drugs can cure HIV/AIDS. Many alternative treatments were also provided by those in alternative medicines but yet the disease is still a problem. Outlook (2003), explained that highly active antiretroviral therapy, the standard of care for most people living with AIDS, can cost more than $12,000 (N1,584,000) per year. This shows the amount of money the PLWHA will need to spend on the ARV drugs so as to enable them maintain the appropriate viral load level.

From table 8.1, majority of the respondents receiving treatment, are on ARV drugs, while some of the respondents revealed that they are not on any treatment. This will make the virus to quickly destroy the white blood cells and this can make the HIV to develop to AIDS. Majority

of the respondents interviewed are receiving treatment at the teaching hospital, while other places of receiving treatment are General Hospital, Military Hospital, Medical Hospital and private hospitals. Since majority of the patients are on ARV, the average amount of money spent on the drug per week is four thousand. This shows that to treat and maintain quality of life with HIV/AIDS is expensive even when considered with the ordinary treatment of ailment. It also implies that almost all the income of the respondents will be spent on the drugs with or without anything left to meet other family obligations. This is also in conformity with the one of the hypotheses that people living with HIV/AIDS may likely spend more on their treatment of the disease. Looking at the income pattern of the PLWHA in table 7.1, it indicates that majority of the people living with HIV/AIDS will not be able to afford the drugs even if they devoted all of their income to the purchase of drugs. Whereas there are other needs to be met. There is now increase in spending for health care, decreased productivity and higher demands for care. One study in Uganda showed that 65 percent of the AIDS- affected households were obliged to sell their properties to pay for care (Food and Agriculture Organization, 2001). AIDS pushes people deeper into poverty as household lose their breadwinners or fell sick, livelihood are compromised and savings are consumed by the cost of health care. Researches show that, in two-thirds of Zambian families where the father died, monthly disposable income fell by more than 80%. In Cote d'Ivoire, income in AIDS-affected households was half that of the average household income (UNAIDS, 2002a).

Since their income cannot cope with the cost of the medical care some of the AIDS patients may resulting in selling their property in other to survive on maintain the stable viral load level in their body. Household incomes plummet when adults fall ill from HIV/AIDS and can no longer work full-time or at all. In rural Zambia, households where the head was chronically ill reduced the area of land they cultivated by 53 percent compared to households without a chronically ill adult, resulting in reduced crop production and lower food availability (FAO 2002). Also the cost of treating illnesses caused by HIV/AIDS place a huge economic burden on families. Studies in urban households show that when family member has HIV/AIDS, the household spends four times as much on health care as unaffected households (UNAIDS 2002a).

TABLE 8.2 COST AND TYPES OF TREATMENT RECEIVED PLWHA

VARIABLES	MALE	FEMALE	TOTAL
What type of treatment , if any what are you are on?			
I am on ARV	+ +	+ +	+ +
I am Not on Treatment	+	+	+
Where did you receive treatment?			
General Hospital	+	+	+
Teaching Hospital	**+ +**	**+ +**	**+ +**
Military Hospital	+	+	+
Nigeria Medical Hospital	+	+	+
Private Hospital	+	+	+
How much did you normally spend on ARV per week?			
N0-2000	+	+	+
N2001-4000	++	++	++
N4001 & ABOVE	+	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

8.3 IMPACT OF HIV/AIDS ON HOUSEHOLDS NEEDS

A downward spiral of the family/household's welfare begins when the first adult in a household falls ill. There is increased spending for health care, decreased productivity and higher demands for care. The impact of the disease within the households will vary according to their productive activities and the economic and socio-cultural context in which they live. The effect of the HIV/AIDS on the family status and on the children was asked from the AIDS-patients. From the respondents, majority of them indicated that their status has affected the need of the family. This was expected looking at the medical cost and the level of income. Most of the people living with HIV/AIDS will not be able to meet the needs of the family since

majority of them are poor. On the needs of the family, the majority of the respondents indicated that to feed their families is now a problem, while other needs mentioned include, clothing paying house rent and children school fees. (UNDP 2001) explains that the illness or death of parents or guardians because of HIV/AIDS can rob a child of the emotional and physical support that defines and sustains childhood, it leave a void where parents and guardians once provided love, protection, care and support. Since HIV is often (but by no means always) transmitted to sexual partners, children are more likely to lose both parents to HIV/AIDS. These are some of the responses by people living with HIV/AIDS and people affected by AIDS on the needs of the family.

A female discussant (PLWHA)

Yes, my status has affected the need of my children. I am unable to give them the necessary care since my case has grown to full blown AIDS and I am a widow. Two of my children have dropped out of school since I could not pay their school fees.

A male (PLWHA)

With my age and the effect of the disease on my health, to maintain the disease, I spend nothing less than N2000 per week on drugs not to talk of eating good food. I could not cope with their needs and my third born could not further her education, she has to start small business (hawking) so as to sustain the family. The last two are with my aged parents in the village".

HIV/AIDS also impacts on the extended families. The responsibilities of taking care of the children usually fall on the grandparents when the infected parents die. Aunts, uncles or other caring adults will assume responsibilities. However, the prevailing hash economic conditions make it difficult for relatives to provide the traditional safety needed by the children of the

people infected with HIV/AIDS. In such circumstances, children themselves take responsibilities for the survival of the family and home. A study shows that in numerous HIV/AIDS affected households children have not only increased the amount of work that they do, but have also assumed decision-making and responsibilities that transform roles within families and households (Desmond *et.al* 2000). Another impact of this disease is that it will lead to increase in the dependency ratio within the study area and the nation as a whole.

Most of the caregivers are also older people. A study conducted in South Africa shows that 84 percent of the care givers are people above 60 years of age. Most of these people also have some problems affecting the provision of care such as loss of remittance and other financial support, high cost of medical fees during illness, inability to pay school fees for orphans, loss of economic support and diminishing livelihood opportunities (UNAIDS, 2004). This was also validated by the response of one of the caregivers who is above 60 years.

" Looking after these children is like starting life all over again, because I have to work even more than what I was used to two years ago. I have to feed these children, buy school uniform. I thought I would not do these again, I don't even have the energy to cope with their stress" (burst into tears)

These children are left in the hand of the caregivers who also cannot meet their needs. They can be exposed to dangers, such as sexual abuse. UNIADS (2004) reports that children without the guidance and protection of their primary caregivers are often more vulnerable and at risk of becoming victims of violence, exploitation, trafficking, discrimination or other abuses.

Surviving children of the people affected with AIDS face malnutrition, illness, physical and psychosocial trauma, and impaired cognitive and emotional development.

Respondents were asked if there are any of their children that drop out of school, some of the respondents explained that their children drop-out of school because they could not afford the school fees and other related expenses with it. Other reasons for dropping out of school are; to help in the family business, and to take care of the younger ones. One reason why children dropped out is thus to support family economically. This also makes children to be vulnerable to this disease. Some children are exposed to a lot of risks, especially when children are not well housed.

16 –year old Young lady(PABA)

There is no helper and we don't want our mother to die, as the first of the five children, I had to stop schooling in order to fend for the family and to take care of our mother since we have lost our father in a motor accident.

As parents and family members become ill, children take on more responsibility to earn income, produce food and care for the family members. It is harder for these children to access adequate nutrition, basic health care, housing and clothing.

Child labour will become the order of the day when the breadwinner of the family is no more. The children will be forced out of school especially the female children to take care of the family, in some instances, giving helping hand to the family business. Foster and Williamson (2000) in their study report that as the parents grow ill, children suffer. There is little money for food or school fees, and children are often forced to take on adult responsibilities. After

their parents die, children may move in with grandparents, or distant relatives, head their own households or survive on the street. They must confront the stigma of AIDS at the same time that they deal with grief, depression, and anxiety-and perhaps cope with their own HIV infection.

Table 8.3 Impact on Household Needs

VARIABLES	MALE	FEMALE	TOTAL
Has your status affects the need of your			
Yes	+ +	+ +	+ +
No	+	+	+
Care Needs	+ +	+ +	+ +
Support Need			
Shelter	-	+	+
Food	+ +	+ +	+ +
Clothing	+	+	+
Paying Rent	+	+	+
Children Schooling		+ +	+ +
Is there any dropout among your children?			
Yes	+	+	+
No	+ +	+ +	+ +
Reasons for drop out			
Paying School fees	+	+	+
To help me in my business	+	+	+
To take care of the younger ones	+	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

8.4 NUTRITIONAL STATUS OF PLWHA

Nutritional care and support are important from the early stages of the infection to prevent the development of nutritional deficiencies. A healthy and balanced diet will help to maintain body weight and fitness. Many of the conditions associated with HIV/AIDS affects food intake, digestion and absorption, while others influence the functions of the body. Many of the symptoms of these conditions (e.g. diarrhea, weight loss, sore mouth and throat, nausea or vomiting) are manageable with appropriate nutrition. Good nutrition will complement and reinforce the effect of any medication taken (Bijlsma, 1996)

The respondents were asked if there were any changes in their nutritional status. most of the respondents indicated that there were changes in their nutritional status. Most of the respondents revealed that they are unable to eat. One of the symptoms of the infection in the early stage is a weight loss but a healthy and balanced diet is necessary to gain and maintain the weight. FAO (2002), explained that one of the consequences of HIV and other infections is that since the wall is damaged, food does not pass through properly and is consequently not absorbed. The body draws on its reserve stores of energy from body fat and protein and resulted into weight lost. Some of the respondents also explained that they were asked to be eating balanced diet by the medical officers, while others said they are now eating more fruits than before. The essence of these is to build the body nutrients and to allow the drugs taken to be effective. Some of the respondents explained that they cannot even afford those foods recommended for them. Majority of those on the ARV drugs make them eat more than before because the drugs require more energy from the body system and this is a possible only when

eating good and balance diet. The type of food recommended for them are very expensive in the study area. It will also increase the household bill on food items leaving little amount of money for other needs.

Table 8.4 Nutritional Status of PLWHA

VARIABLES	MALE	FEMALE	TOTAL
Is there any changes in your Nutrition?			
Yes	+ +	+ +	+ +
No	+	+	+
How ?			
Eating well	+	+	+
Not being able to Eat	**+ +**	**+ +**	**+ +**
Eating much fruits	+	+	+
Eating balance diet	+	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

8.5 CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS

People living with HIV/AIDS must overcome socio-cultural and economic barriers to get the care and support they need. The stigma associated with HIV/AIDS makes many people reluctant to admit they are infected or seek care. Care for people living with HIV/AIDS falls into three broad categories: (1) palliative care and social support to relieve symptoms, address nutritional and welfare needs, provide psychological support, and cope with social stigma.: (2) diagnosis, treatment, and prevention of opportunistic infections and HIV-related illnesses; and (3) treatment with antiretroviral drugs (Outlook 2001)

However, palliative care does not attempt to treat HIV/AIDS, rather it improves patients' quality of life by treating their symptoms and offering them and their families psychological, social, and spiritual support. This is the type of care and support that can be given to people infected with HIV/AIDS. The people infected and affected by HIV/AIDS were asked some questions about the care and support they receive from their families and relatives. The responses from the people infected from HIV/AIDS varies, some people receive financial assistance, emotional and physiological support, while some of the respondents indicated that they did not received any support from their relatives. The economic condition in the country may not allow people to render assistance even if they have the mind to do so. It was interesting to observed that only female respondents indicated that they take care of her children. It is the believe that once the man is alive he should be able to manage or cope with his family especially when his wife is still alive and the stigma may also debar men from telling the relatives that he needs assistance from his relatives. Also in a situation that the infected person is the breadwinner for the entire family, he is left to his immediate or nuclear family to provide the necessary care and support needed by him

Table 8.5 Care and Support for PLWHA

VARIABLES	MALE	FEMALE	TOTAL
What are the contribution of your relatives toward care and support of			

your family?			
Nothing	+	+	+
Taking care of my children		+	+
Financial support	+	+	+
Emotional and physiological support	+	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

The people affected were asked the similar questions about the care and support rendered to their relatives infected. From table 6.15, some of the respondents revealed that they normally follow the patients to the health facilities, some pay the hospital bill, especially if the husband is negative, some prayer and others give them the psychosocial and emotional support needed by the people infected.

TABLE 8.6 CARE AND TREATMENT RENDERED BY PABA

VARIABLES	**MALE**	**FEMALE**	**TOTAL**
What is your role in the treatment ?			
Following him/her to health facilities	+	+	+
Paying the medical bill or drugs	+	+	+
Taking him to where he /she can receive healing	+	+	+
Give Him \ her words of encouragement	+	+	+
Praying for him \ her	+	+	+

Note + + opinion expressed by most of the respondents (above half)
+ opinion expressed by some of the respondents (below half)
- opinion not expressed at all.

8.6 IMPACT ON LIFE EXPECTANCY

In many countries of sub-Saharan Africa, AIDS is erasing decades of progress in extending life expectancy. Life expectancy reflects the conditions in community, but also affects condition in the community. Average life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. In Nigeria the life expectancy is now 43 years from 54years, this shows the impact of the disease on the country. From table 7.1 majority of the respondents (59.6%) in the study are in age group 21-40 years. This implies that if there is no adequate care they may likely to die before they reached aged 50.

SUMMARY

The study revealed that HIV/AIDS has impact on the household income. Some of the PLWHA pointed out that they have sold part of their properties to pay off medical bills. The cost and type of treatment received by PLWHA are expensive, the average amount on money spent weekly to acquire the necessary drugs and medication is N4,000. Most of the respondents cannot afford this, and where they can, it affects their other needs in the family.

The high cost of drugs did not allow some of the infected person to receive treatment from the hospital, and this will allow the virus to develop to a full blown AIDS. The high cost of treatment has affected the needs in the family, majority of the respondents indicated that their needs have been affected. They could even meet the basic necessities of life. Some of the respondents also revealed that they had withdrawn some of their children from school since they cannot afford the school fees and other related expenses. Some of the children of the

infected persons are now in the hands of the care-givers, with the present economic conditions, cannot be properly cared for because some of the relatives cannot cope with the additional responsibility. These make the children to assume the adult role in the family. This will increase the menace of child labour in the study area if this issue is not adequately addressed quickly .

Nutritional care and support is one of the palliative care for the people living with HIV/AIDS. Most of the respondents complained of changes in their nutritional status. Some could not eat very well while some were asked to be eating fruits and balanced diet. This is to provide the necessary vitamins and nutrient needed by the body system since the virus is destroying the white blood cells in the body. Eating good and balanced diet will help the infected person to maintain the viral load in his/her body system. The most unfortunate part of it is that some of the respondents could not even afford the type of food required for their body to be able to meet the necessary health requirement. This is due to high cost of food items and fruits in Lagos and its environment since most of these fruits and food stuffs were brought from the northern part of the country.

Interestingly, most of the respondents looked for alternative medicine or solutions to their problem. They believed that traditional medicine can find solution to their problem. All their efforts did not yield any positive result. Most of the respondents still believe in faith healing. They believe that since God is the creator of heaven and earth, there is nothing He cannot do.

Some of them tried to exercise their faith by not taking drugs while others combined two together.

CHAPTER NINE

SUMMARY, CONCLUSION AND RECOMMENDATION

This study is borne out of the fact that the current statistics about HIV/AIDS epidemic, as devastating as they are, do not reveal the broader social and economic impacts of the disease in Nigeria. It is primarily aimed to fill the gap in knowledge in the area of HIV/AIDS, since recent scientific efforts have resulted in a series of discoveries and advances in understanding and controlling the virus that causes AIDS but had limited impact on the infected people. The main objective is to examine the socio-economic consequences of living with HIV/AIDS and its implications for the spread of the diseases within the nation.

The choice of Lagos State for the study is borne out of the fact that the state is one of the states in the country with highest prevalence rates and this has a great implications for the spread of the disease in the country. Also being a state with largest commercial and industrial centres, aided by her function as the chief port of the country. It was formerly the seat of the federal capital from 1960-1991, which encourage the migration of different people with diverse ethnic groups from different part of the country. The data used were collected using triangular method, in which 1358 respondents were selected from the general populace and 188 people living with HIV/AIDS were interviewed through support groups in the State.

The composition of the age group shows that majority of the respondents are between 25-44years. More than half of the male respondents and 38% of female respondents are married

while 21.2 percent of the female respondents are widows. There is a high level of literacy among the respondents in the study area. Males with no education are higher than female respondents. Two-thirds of the respondents are Christians while 37 % are Muslims. The analysis also revealed that majority of the respondents are earning less than N120,000 per annum. More than half of the respondents are employed in sales services regardless of their sexes while more females are in civil/public service. The ethnic composition shows that half of the respondents are Yorubas in the study area.

In an environment of overcrowding, this will aggravate sexual exploitations among young females and women will be aggravated. Fifty-two percent of the respondents are living in one-room apartment with an average of six to seven persons in a room. This also reveals the level of poverty among the respondents.

There is high-risk sexual activity in the study area, from the survey more than two third of the male respondents and half of the female respondents had intercourse in the last twelve months with other partners apart from their spouse. This is one of the reasons why the state has the highest HIV/AIDS prevalence rate in the country.

Three-quarters of male respondents and one-quarter of female respondents have more that two sexual partners in the last twelve months preceding the survey. Four out of every five male respondents and three out of five had intercourse with casual partners while only male respondents indicated that they had intercourse with prostitutes.

From the study, half of the male respondents have the affairs within the same city, two-fifth of the female respondents had intercourse in the same city. The percentage of female respondents that have the affairs in other centres doubles that of male respondents while more male respondents had sexual intercourse in the rural areas. This is one of the reasons HIV/AIDS is now found in the rural area. It also shows the sexual networking in the study area.

However, condom are the proven barrier method for reducing the risk of all sexually infections. Twenty-one percent of the male respondents and sixty percent of female respondents reported the use of condom in the last intercourse. This reveals that females are now conscious of the importance of condom. Majority of those that engaged in sexual intercourse did it under the influence of alcohol which also will affect the consistent use of condom.

The exchange of gifts is significant in the creation and maintenance of social relationships in the study area. Sixty-eight percent of males and 30% females indicated that they often had exchanges for sex.

Knowledge of sexually transmitted disease is universal among male and female respondents. All the respondents have heard of STIs before the most widely reported are HIV/AIDS, gonorrhea and syphilis. This shows that knowledge of the disease is high in the study area due to the literacy level of the respondents. People with formal education are more likely to have access to health education. It also implies that the past programmes that have been undertaken

by government and Non-governmental organization to inform the general populace about the HIV and other sexually transmitted diseases has had some impact in Nigeria. The mass media, especially television and radio reach large numbers of people in the country and they are the major sources of information mentioned by the respondents.

There is no misconception about the mode of transmission of the HIV virus, since knowledge about the mode of transmission is important in the prevention of HIV/AIDS, four out of every five of the respondents knew the mode of transmission of the disease.

Treatment of sexually transmitted infections is one of the ways of lessening the easy transmission of HIV/AIDS, 90% of male and 78% of female respondents sought treatment when they were infected with STI. Majority of those who sought treatment did so in government hospital while more female respondents sought treatment from the traditional healers.

Communication between sexual partners regarding sexually transmitted infections was poor. Only half of female and 44 percent of male respondents informed their partners about their infections. Majority of the women did nothing to prevent the transmission of the disease to their partners.

Among those that had intercourse, young females got involved more in the multiple affairs than males. Sexual intercourse apart from spouse also increases with age among male respondents. Interestingly women in older ages involved in extramarital affairs are more than

those in the lower age. More married men were involved in extramarital affairs while 88% of females who are single had premarital sex with other men apart from their partners.

Religion did not have any impact on the sexual affairs of the respondents, 72% of males who are Christians and 42% of males who are Muslims had sex with other partners apart from their spouse, while more female Muslims had sex with other apart from their spouse. Forty-seven percent of females who earn less than N120,000 had intercourse apart from their spouses while extramarital affairs increases with income among males in the study area. It was also observed that those with post secondary education have more extramarital affairs when compared with others. They are likely to have the economic power to attract women.

The use of condom increases with age among the respondents which is also supported by the previous findings. It was also observed that 63% of female respondents above 35 years used condom in the last sexual affairs. The age at first intercourse also increased with the condom use in the study area.

Knowledge of AIDS is necessary to recognize one's behaviour as high risk in order to take action to change that behaviour. Sixty-four percent of males and 48% of females who had good knowledge of HIV/AIDS had sexual intercourse apart from their spouse in the last twelve months preceding the survey.

Only half of the respondents were willing to do HIV/AIDS test. This shows the attitude of the respondents to sexual change. Majority of the people are afraid of the possible outcomes of the

test. They believe that it is better not to know about the status and continue the normal life than go for the test and die gradually before the real death, having forgotten that knowing the status will help in reducing the transmission of the virus and will also help those infected to manage it and live long. This shows that people do not have enough knowledge about the Voluntary Counseling and Testing (VCT).

The secrecy of those that were affected and the stigma attached to it by the society does not allow people to disclose their status. Majority of the respondents are not aware of people infected with the disease. They are just hearing it. This also creates doubt in the minds of some respondents as to whether the disease even exist at all.

With respect to people living with HIV/AIDS, 66% of females and 44% of males are in age group 21-24 years. This is the sexually active group within the population. The findings also show that older people are increasingly being infected with HIV/AIDS: 10% of male respondents who are above 60 years of age reported that they are infected. Surprisingly, more males than females who are single are infected , while more than half of the females who are infected with HIV/AIDS are married.

The survey also revealed that poverty is one of the factors fueling the spread of HIV/AIDS in the study area, three out of every five infected with HIV are living below N120,000 per annum. It was also discovered that there is a positive relationship between education and being infected with HIV. Female respondents infected increase with the level of education, while males with post secondary education has the highest infection with HIV. It was found out from the survey

that majority of the infected got to know of their status when they fell sick. The study also revealed that TB is the most common infection among, and leading killer of, people with HIV/AIDS. It was discovered that STIs greatly facilitate HIV transmission among the infected persons. Most of them have been treated for one STI or the other before being confirmed positive. It observed that majority of the respondents did not visit the right health facility for the treatment of the STIs when they are infected because of the stigma attached to it that it can only be contracted through immoral acts.

It was also discovered that some of the respondents, after being diagnosed still have sexual relations with multiple partners. Some of the reasons for continuing this act was that they don't believe that they have the disease, while others want to take revenge on other people. The study also revealed that circumcision does not reduce the risk of infection, especially in males. Most of the respondents that were circumcised are infected with the virus.

Majority of those are infected have disclosed their status to at least one person among their families and friends, although they revealed that it took them time before they could do so, for the fear of being stigmatized or ostracized from the family. A few are yet to disclose their status based on the same reason.

Surprisingly, some of the relatives that heard about the HIV/AIDS status abandon them while some were stigmatized by their friends and relatives. Majority of the respondents who have children did not inform their children so as not to create fear in them, while some believed that

they are too young and they may not understand what they are saying. Those above 60 years believed that they can be abandoned by their children.

Various reactions were exhibited by the families and relatives of the infected people when they heard about the status, some felt bad, surprised, didn't believe it, and wept when they heard the news. It was also discovered that few of the infected people were sent away from their home without allowing them to have access to their property, especially women. The findings also revealed that the health workers also discriminate against those that are infected for fear of being infected. They stigmatized and ostracized them in the hospital. In some hospitals signs are even placed near people living with HIV/AIDS, which adds to their feelings of loneliness and abandonment.

One of the objectives of the study was to examine economic implications of living with HIV/AIDS, it was discovered from the findings that an average of four thousand naira will be spent on ARV per week which is rather high when compared with the level of income received by the infected people. This also confirmed one of the hypotheses that people with HIV/AIDS may likely spend more of their income on the treatment of the disease. Majority of the respondents cannot even afford the drugs. Their income cannot cope with the cost of the drugs.

The study discovered that the status of the parents have affected the needs of their children, some of the parents cannot afford the school fees of their children. Some of the infected

persons have had to send their children to stay with their relatives especially the aged parents in their home towns or villages while some of the children of those that are infected that are old enough have started fending for the family. The finding revealed that the incidence of HIV/AIDS if not properly controlled, will lead to a situation whereby child labour will become the order of the day when the bread winner of the family is no more or cannot afford the basic necessity of life. Females are forced to take care of the families or assist in the family business.

The findings also revealed that as the HIV/AIDS strikes at the heart of the family and community, large numbers of older people are assuming responsibility for bringing up the children of the infected persons and orphans. Some of the older caregivers cannot even meet the requirement of these children. They are often forced to work more than they would have or borrow in order to cope with the needs of these extra mouths. There were also changes in the nutritional status of the people infected with HIV/AIDS. The respondents explained that they were asked to be eating good food, more fruits and vitamin since the drugs they are taking require energy. Some of those infected reported that their income cannot cope with the required foods. It was also revealed that some of the relatives of the infected people took them to receive alternative treatment. Some of the relatives also provide care and support for them since they leant of their HIV/AIDS status.

POLICY IMPLICATIONS

According to UNAIDS estimates for 2004, there were 35.7 million adults and 2.1 million children living with HIV at the end of 2003, and during the year 4.8 million new people became infected with the virus. However, since each year there are more and more new HIV infections, this shows that people either aren't learning the message about the dangers of HIV, or are unable or unwilling to act on it. Education is an important component of preventing the spread of HIV. Government should make AIDS Education compulsory in the country. Each generation must be educated. The older generations, who have hopefully already been educated, may need the message reinforced, and need to be kept informed, so that they are able to protect themselves and inform the younger.

All the same, HIV/AIDS is placing tremendous strain on the already limited resources and capacity of older people who are caring for orphans and vulnerable children. Government should develop policies and programmes that address the psychological needs o orphans and vulnerable children. The policy must also address their health needs. The low status of women makes them socially vulnerable to HIV, they have limited opportunity for employment, often no right to work or to own or inherit land and property in their own names; limited access, if any to finance their own business ventures; and often limited access to health care services. It is necessary for government to take step to deal with all the social and economic factors that make girls and women especially vulnerable to HIV infections.

Further more, worldwide, there are around 33 million new STIs excluding HIV, every year, of which at least 50% are in young people under 25 years (UNAIDS 2000). Although most STIs

are easily cured, but frequently women are unaware of their presence because the symptoms are not obvious or they are stigmatized when they showed their discomfort about the symptoms. Since the study has shown that the presence of another STI increases a person's susceptibility to HIV, strengthening STI control can have a dramatic impact on lowering HIV transmission rates. Government should provide good quality , user friendly prevention and care programmes for other STIs, the presence of which increases the risk of HIV transmission.

Voluntary counseling and testing for HIV is a necessary precursor to developing effective treatment, care and support services including programmes to reduce mother-to child transmission, preventive therapy for tuberculosis, or the administration of antiretroviral therapies. VCT may also reduce reported risk behaviour and prevent new infections –notably among those testing positive and among discordant couples. Government should provide a policy or law that would make VCT compulsory for every body in the country. This should be done regularly to reduce the transmission of the HIV virus in the country. People should have access to this service in the country. Government should provide this service in cities, town and villages in Nigeria.

Poverty has been observed as one of the most important factors fueling the spread of HIV/AIDS in Nigeria and OTHER African countries. Reducing HIV/AIDS in this region of the world will require government effort to reduce the level of poverty affecting people. Government should intensify efforts or provide programmes and policy at the three tiers of

government in Nigeria that will reduce the level of poverty. Unless this is addressed all other efforts that are put in place may not likely yield a positive result.

RECOMMENDATIONS

- People should be educated on how to prevent new infections from taking place. This can be seen as consisting of two processes:

- Giving people information about HIV/ AIDS how they are transmitted, and how people can protect themselves from infection.

-Teaching people how to put this information to use and act on it practically - how to get and use condoms, how to suggest and practice safer sex, how to prevent infection in a medical environment or when injecting drugs.

- Educate people living with HIV/AIDS, since most of the messages are always targeted only at people who are not infected with HIV in order to prevent them from becoming infected. When AIDS education with HIV positive people is considered at all it is frequently seen only in terms of preventing new infections by teaching HIV+ people about the importance of not passing on the virus. An important and commonly-neglected aspect of AIDS education with HIV positive people is enabling and empowering them to improve their quality of life. HIV positive people have varying educational needs, but among them are

the need to be able to access medical services and drug provision and the need to be able to find appropriate emotional and practical support and help.

- People should be educated on stigma and discrimination regarding HIV/AIDS and people living with HIV/AIDS among the adults. Stigma and discrimination associated with HIV and aids are the greatest barriers to preventing further infections, providing adequate care, and alleviating suffering. The stigma surrounding sex and sexuality, sexuality, has prevented millions from receiving information about HIV, how it is transmitted, and how to protect themselves. discrimination has also prevented people with HIV from being open about their status and getting access to treatment. people with, or suspected of having, hiv have been turned away from health care services, denied housing or employment, shunned by friends and colleagues, divorced from their spouses, and even murdered. avoiding stigma and challenging norms has partly depended on overcoming the widespread judgment that certain people living with hiv/aids in the society

- Women must be empowered in their rights to sexual and reproductive health, equal access to information and education, economic independence and equality at home.
- There is a need to conduct rural education to raise awareness and knowledge of human rights, developing a positive sexual culture and interpersonal communication skills, e.g. the ability to talk about sensitive issues, constructive conflict resolution, development of the

self-assurance and self-esteem of women, and the empowerment of women to negotiate safe sex.

- It is essential to involve men in education because only with their support and understanding will women be able to negotiate safe sex and protect themselves from HIV/AIDS.
- Sexual and reproductive health and life skills must be incorporated into school curricula if education is to help the fight against HIV/AIDS.
- Sexual education of adolescents has to be intensified, in order a) for young people to develop a better understanding and healthy attitudes towards sexuality and sexual relationships, b) to foster a positive perception of sexuality among adolescents, c) to foster their responsibility for their own and their peers' sexual and reproductive health, d) to protect them from early sexual intercourse and its potentially negative consequences, e) to reduce the risk of HIV/AIDS/STIs.
- Gender mainstreaming in national /state policy has to be aware of prevailing gender stereotypes in the sphere of sexual and reproductive health (behaviour, attitudes, knowledge), as well as of other factors influencing the vulnerability of women and men in the sexual sphere. Special attention should be devoted to the existence of domestic and sexual violence, discrimination and inequality of women in the family.
- Powerful information campaigns should be carried out through mass media directed at the formation of a positive sexual culture in the population and the elimination of the

current cultural traditions and social norms restricting the rights and opportunities of women and girls.

- Motivation is a very important, people need to know that what they are learning about the epidemic is personally relevant to them. They need to know that they themselves can be affected by HIV if they do not take steps to protect themselves.
- Empowerment is also crucial to people's ability to protect themselves. They must be in a position where they are able to take control of their sexual behaviour.

- Condoms should be available and affordable. There is little point in teaching people about the need to practice safer sex if they are unable to access condoms. Ideally, condoms should be freely available, and should be accessible to young people, regardless of whether they are over the age of consent or not.
- The attitudes and behaviours of those both providing and receiving treatment are crucial if the treatment is to be safe and effective. The health workers must not discriminate against people living with HIV/AIDS when they are at the health facility.
- Creation of employment for both males and females. This will reduce commercial sex workers whose numbers increased because of economic frustration and survival strategy

AREAS OF FURTHER REASERCH

In order to develop new effective approaches to the control of HIV/AIDS through sexual relations, it is necessary to assess young people's newly acquired, contemporary patterns of

behaviour, which has negative influence on their sexual and reproductive health. It also expedient to carry out research on the impact of the HIV/AIDS on the family support system in the African society .

REFERENCE

ACTION AIDS (2000) Religion and HIVAIDS : The international Newsletter on HIV/AIDS prevention and care April-June no 47

Adegbola O. and Babatola.O (1999) : Premarital and extramarital sex in Lagos, Nigeria. in The continuing HIV/AIDS Epidemic in Africa : Responses and Coping Strategies. (eds) Orubuloye, Caldwell. J.C and James P.M, *Health Transition Review* 19-44

_____and Oni. J (1995) Sexual networking, in Freetown against the background of the AIDS epidemic in Orubuloye I.O. Caldwell JC. Caldwell Pat, Shin Jain, the third world AIDS *Epidemic Health Transition Review Suppl to vol 5 68-80*

Adeokun L and Nalwadda R. (1997) Serial marriages and AIDS in Masaka District. In Vulnerability to HIV infection and Effects of AIDS in Africa and Asia/India. *Health Transition Review* (eds) Ntozi J.P.M, Anafi, J.K, Caldwell J.C, and Jain S

Adepoju A. (2004) Reproductive Health and Poverty: Commission paper for the National Reproductive Health Consultative Summit Abuja 16-19 Feb

Adepoju A. and Ogunjuyigbe O. (2004) Adolescent Sexual and Reproductive Health in Nigeria: Behavioural Patterns and Needs. Report Human Resources Development Centre.

Adeyemi. E.O (1999): AIDS, Social Environment and Adolescent Sexual Behaviour in Osogbo and Olorunda Local Government Areas of Osun State. M.Sc Dissertation

Afonja, S (1990). Changing patterns of gender stratification in West Africa in *Persistent Inequalities*, (editor, I Tinker). Oxford University Press, New York. P 209.

ccl

AfriAfya (2002)– HIV/AIDS Notes: Exchange Support tool. March

Agandijan V and Prata N,(2000): Civil war, infant mortality, and Child Morbidity. Paper.

Aggleton P. (1996) Global priorities for HIV/AIDS intervention research. *International Journal of STD AIDS 7 (Suppl 2):13-6.*

Ajzen & Madden (1986). "Prediction of Goal-Directed Behavior: Attitudes, Intentions, and Perceived Behavioral control," *Journal of Experimental Social Psychology, vol. 22, pp. 453-474.*

Allen, Susan et al (1991). HIV Infection in Urban Rwanda. *Journal of the American Medical Association, 25 September , Vol266, 1657.*

Allen, S Tice, J, Vander- Perre, P, Serufilira A et al (1992) Effect of serotesting with counseling on condom use and seroconversion among HIV discordant couples in Africa. *British Medical Journal,* 304 1605-1609

Altman, L.K (1999) “More African women have AIDS than men” . New York 24 Nov.

Amuyunzu-Nyamongo M, Tendo-Wambua L, Bbabishangire, J.N. NyageroN, Yitbarek, M, Matasha and T. Omurwa.(1999) Barriers to behaviour changes to STD including HIV/AIDS: the East Africa experience. in John Caldwell et al : resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries. *Health Transition Review*. 1-12

Anarfi, J.K. (1993) : The condition and care of AIDS victims in

Ghana:*AIDS suffer and their relations pp 253-263*

Anderson, R.M. May R.M, Boily , M.C, Garnett, G.P. and Rowley,

J.T (1991) " The spread of HIV-1 in Africa: sexual patterns and the predicted demographic impact of AIDS' *Nature, 352, 581-589*

Andima J.J (1994) Namibia women and Land. *Southern African*

Political and Economic Monthly 7,6: 48-49

Andrew S. London, Mark J, Vanlandingham and Nancy Grandjean.

(1997):`Socio-Deomgraphic correlates of HIV\AIDS- related factors and measures of same sexual beahiour among Northern Thai male solders . *Health Transition Review 33-60.*

Angyman D.K. (1993) Families, neighbours and the AIDS epidemic.

Paper presented at workshop on AIDS Social Dimensions of HIV/AIDS, University of Cape Coast 18-20 October 1993.

Ankomah . A (1992) Premarital sexual relationships in Ghana in

the era of AIDS: *Health policy and planning, 7: 135-143.*

Aroye, M.O. Onite B.A.and Jolayemi E.T. (1996) Sexual behaviour

and condom acceptance among Nigerian drivers: West Africa *Journal of Medicine15, 1: 6-10.*

Arsendse, I (2004): Male Circumcision and HIV Associate Press.

Ashton P and Ramasar V (2002) Water and HIV/AIDS: Some strategic

considerations in Southern Africa in A.R. Turton & R. Henwood, Eds) *Hydropolitics in the Developing world: A southern African Perspectives Pretoria: African Water Issues Research Unit*

Awusabo-Asare K. and Anafi J.K. (1999) : Rethinking the circumstances

surrounding the first sexual experience in the era of AIDS in Ghana in The continuing HIV/AIDS Epidemic in Africa : Responses and Coping Strategies. (eds) Orubuloye, Caldwell. J.C and James P.M, *Health Transition Review* 8-18

---------- (1999) Routes to HIV transmission

and intervention: an analytical framework. in The continuing HIV/AIDS Epidemic in Africa : Responses and Coping Strategies. (eds) Orubuloye, Caldwell. J.C and James P.M, *Health Transition Review 1-8*

Baden S and Wach H (1998) Gender, HIV/AIDS

transmission and impacts: a review of issues and evidence. *Bridge Institute of Development studies, Brighton. Report no 47*

Barnett, T and Haslwimmer, M (1995) The impact of

HIV/AIDS on Farming System in Eastern Africa, *United Nations Food and Agriculture Organisation, Rome. Pp 182 ISBN 92-5 1036-11-X*

Barnett T and Rugamela (1994): The HIV/AIDS Epidemic and

Food Security. *Food and Agriculture Organisation, Rome.*

Barnett T and Balkier P (1992) AIDS in Africa its present and future

impact. *Belhaven Press London and Gad ford Press New York pp 203.*`

Bassett M, and Sherman J. (1994): Female sexual behaviour and the risk of

HIV infection: an ethnographic study in Harare, Zimbabwe. Washington DC, International Centre for Research on Women.

Bassett, MT, Latif AS, Katzenstein DA and JC Emmanuel (1992): Sexual

behaviour and risk factors for HIV infection in a group of male factory workers who donated blood in Harare, Zimbabwe, *Journal of Acquired Immune Deficiency Syndrome 5 556-5598*

Bechu. N (1998) The Impact of AIDS on the economy of families in Cote d'Ivoire: Changes in consumption among AIDS-affected households. In M Ainsworth, L Fransen and M Over (eds) Confronting AIDS :Evidence from the developing world: selected background papers for the World Bank Policy.

Bennel P, Hyde k, Swainson N (2002) the impact of HIV/AIDS epidemic on the education sector in sub Saharan Africa: a synthesis of the findings and recommendations of three country studies center for international education institute of Education, University of Sussex. England.

Berger, A (1994) Women's reproductive health: women left destitute by AIDS. *British Medical Journal 308 (6931): 789-790*

Billy J.O., Brewester . K.L and Graddy .W.R (1994): Contextual effects on the `sexual behaviour of adolescent women. *Journal of Marriage and the Family 56: 2: 387-404.*

Bijlsma, M (1996): Living positively: a nutrition guide for people with HI/AIS. Second ed. 1997. Mutare City Health Department, Box 910 , Mutare Zimbabwe

Bleek W, (1981) Avoiding shame: the ethical context of abortion in Ghana. *Anthropological Quarterly 54, 4:203-209*

----------(1987 Lying informants: a fieldwork experience from Ghana. *Population and Development 13, 2314-322*

Bloom, J.R. (1990) : The relationships of social; support and health. *Social Science and medicine 30, :635-637*

Boerma J.T, Nunn, A.J and Whitworth, J.A.G (1998) Mortality impact of

the AIDS epidemic evidence from community studies in less developed countries. *AIDS 12 (Suppl 1)*

Bongarts, J.O. (1990) " A model of the spread of HIV infection and the demographic impact of AIDS. *Statistics in Medicine 8, 103-120.*

Bongarts, J.O, Frank and Lesthaeghe, L (1984) : The proximate determinants of fertility in sub-Saharan Africa. *Population and Development Review 10: 511-537*

Booyle F R (2001) The socio-economic impact of HIV/AIDS on households in South Africa pilot study in welcome and qwaqwa, free state province (draft interim report).

_____ (1998) : The global impact of HIV bridging over widening gap coverage from the 12th World AIDS conference June 29-July 2,

Boroffice (1995): Women's attitudes to men sexual behaviour in Orubuoye I.O. Caldwell JC. Caldwell Pat, Shin Jain, the third world AID0S Epidemic Health Transitional Review suppl to vol 5 58-66

Biswas, M. S, Van Niekerk, P.H & Van Rooyen, J.A (1997): Overview of water resources availability and utilization in South Africa DWAF Report P RSA/00/0197.

Buvinic M, and Yudelman S. (1989). Women, poverty and progress in the Third World. New York, Foreign Policy Association,

Bwayo, J., Plummer. F, Omaril M (1994): HIV infection in long distance

truck drivers in East Africa, *Archives of International Medicine 154, 12 1391-1396.*

Caldwell , J. O, I.O. Orubuloye and Pat Caldwell (1992) Under reaction to AIDS in sub-Saharan Africa.. *Social Science and Medicine 34, 11 11169-1182*

Caldwell , J. O, I.O. Orubuloye, Gigi S and Caldwell, P (1993): Sexual Networking and HIV/AIDS in West Africa. *Health Transition Review Suppl to vol 3*

Caldwell P (1995) Prostitution and the risk of STDs and AIDS in Nigeria and Thailand in Orubuloye I.O. , Caldwell J.C Caldwell P. and Shail, J *Health Transition Review Suppl to Vol 5*

Caldwell JC, Caldwell P, Quiggen P. (1989) The social context of AIDS in sub-Saharan Africa. *Population and Development Review, 15:185-234.*

Caldwell P, Caldwell C and Orubuloye I (1999) Obstacles to behavioural change to lessen the risk of AHIV infection in the African AIDS epidemic: Nigerian research in Caldwell P, Caldwell C and Orubuloye I Resistance to Behavioural Change to Reduce HIV/AIDS infections in Predominantly Heterosexual Epidemic in Third World Countries. *Health Transition Review, Australian University, Canberra.*

Cameron, E (2000): Breaking the Silence. Opening remarks at *International Conference on AIDS*, Durban, South Africa, 13, 1

Campbell Carole A. (2001) *Women, Families, and HIV/AIDS: A Sociological Perspective on the Epidemic in America* New York

Carovano K. (1992) More than mothers and whore: redefining AIDS prevention needs of women. *International journal of Health services 21: 131-142.*

Cates JR, Alexander L, Cates W (1998) Prevention of Sexually Transmitted Diseases in an Era of Managed Care: The Relevance for Women, Women's Health Issues; Vol. 8; pp169-186

Centre for Disease Control (2001) : Stigma and Discrimination Against People Living With HIV/AIDS. Technical Paper New York.

Carrel, Cleland U and Ingman, R "Extramarital Sex: Implications of survey results for STD/HIV Transmission" *Health Transition Review, Supplement to Vol 4 p161*

Chigbo, M (2002) Igbinedion versus Prostitutes www.onlinenigeria.com/aids/edo_prosti.esp

Cobb. S (1976) Social Support as a moderator of life stress. *Psychosomatic Medicine 38:5: 300-314.*

Coleman, H. and Charles, G (2001) Adolescent sexuality: A matter of condom sense. *Journal of Child and Youth Care,* Vol.14 (4) pp17-18

Cullinan Kerry (2004): "Change is pain". www/csa/za.org

Denzin, N.K., and Lincoln, Y.S. (1994). Handbook of qualitative research. London: Sage

Desmond C, Michael K and Gow G (2000) " The hidden battle: HIV/AIDS in the household and community' *South African Journal of International Affairs Vol 7 No2*

Dominique et al (1997) : " Main girl friends, girl friends, marriage, and money: the social context of HIV risk behaviour in sub-Sahara Africa. *Health Transition Review Suppl Vol 7 pg 361-375*

Dune et al (1994) Religiosity, sexual intercourse and condom use among university students" *Australian Journal of Public Health. Vol 18(3) pg 339-341.*

Durrant, N (1994) " Impact of AIDS on Women in Uganda" Michigan State University. Office of Women in International Development No 249, East Lamsung, Michigan

Ebigbola J.A and Omideyi, A.K (1988) " Fertility Behaviour in an Urban Centre: A Case Study of Married Women in Ilesa, Oyo State, Nigeria" DSS Monograph, No.3Department of Demography and Social Statistics, Ife (ed.) AA Adewuyi.

Egal F, Valstar A (200) HIV/AIDS and nutrition : Helping families and communities to cope. Rome: *Food and Agriculture Organisation.*

Falkenmark, M 1989: The massive water scarcity now threatening Africa: Why isn't it being addressed? *Ambio 18(2): 112-118*

Fazio, R. H. and Zanna, M. P. (1981) "Direct experience and attitude-behavior consistency," *Advances in experimental social psychology, vol. 14, NY: Academic Press*

Family Health International (1993) *AIDS* Vol 13 No 4

Fishbein, M. and Ajzen, I. (1975) Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research, Reading, Mass: Addison-Wesley.

Food Agricultural Organization (2001)“ The Effect of HIV/AIDS on Agricultural Production and Productivity and the Role of Extension Services in Combating the Disease in Rural Areas”. Technical Paper.

FAO (2001) The impact of HIV/AIDS on Food Security committee on World food security Twenty-seventh session Rome, 28 May –I June

Foster G and Williamson, J.A Review of current literature on the impact of HIV on children n in sub-Saharan Africa *AIDS 14 (suppl 3) S275-284*

Frudenthal, S (2001) A review of Social Science Research on HIV/AIDS Sida/SAREC Reports.

George A, and Jaswal S (1995) Understanding sexuality : An ethnographic study of poor women in Bombay. Washington, DC, International Centre for Research on Women, (Women and AIDS Programme Research Report Series, no 7)

Gifford, S.M. Suanching, J Tusing, Neng Ngaih Lian, B. Langkham and Mauna VL (1999) The social context of risk and protection amongst young people and women in Churachandpur, India in Caldwell J, Caldwell, P Anafi J Kofi Awusabo-Asare et al Resistance to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries. *Heath Transitional Review.*

Gilks C.F. (1998) : The challenge of HIV/AIDS in sub-Saharan. Africa *Journal of the Royal college of Physicians of London, 33 (2) 180-185.*

Gleick, P.H (2000) The changing water paradigm: A look at the twenty-first century water resources development. *Water International 25(1): 127-138*

Glesne, C.,and Peshkin, A. (1992). Becoming qualitative researchers: An introduction. New York: Longman.

Goldsten, D.M (1995) : AIDS and Women in Brazil. The emerging problem in *Social Science and Medicine Vol 39, No7*

Gregson, S, Zaba, B and Garnett G.P (1999) : Low fertility in women with HIV and the impact of the epidemic on orphanhood and early childhood, mortality in sub-Saharan Africa *AIDS 13 (Suppl A)249-257.*

Hamblin J, Reid E. (1995): Women, the HIV epidemic and human rights, New York, UNDP (HIV and Development Program): A sub –Saharan case study. Paper presented at the population Association of America Annual Meeting. Los Angeles 23-25 march.

Haram L. (1995) Negotiating sexually in times of economic want: the young and modern Meru women. In: Klepp KI, Biswalo P, Talle A, editors. Young people at risk. fighting AIDS in Northern Tanzania. Oslo: Scandinavian University Press; 1995.

Health System Trust (2004) Health worker excellence campaigning News Letter

Herek G.M. (1999): AIDS and Stigma: An Behaviour Scientist 42(7)

Hue, L and Kaufman C (1998) " Creating positive attitudes toward persons living with HIV/AIDS among young people in hostile environment" Presented at the International Conference on AIDS, Geneva, Switzerland, 28 June- 3 July, 12: 970

Hogsborg M and Abby P (1992) sexual relations , use of condoms and perception of aids in an urban area of Guinea-Bissau with a high prevalence of HIV-2 in Tim Dyson sexual behaviour and networking : anthropological and socio-cultural studies on the transmission of HIV. IUSSP.

Hofferth, S.L and Hayes, D.C (1987) Risking the future, Adolescent , Sexuality, Pregnancy and Childbearing : National Academic Press Washinton DC.

Horizons project (2000) : Peer education and HIV/AIDS: past experience, future directions. New York: Population Council.

_____ (2001): Interventions to Reduce HIV/AIDS Stigma New York: Population Council.

Hunt CW. (1989) Migrant labour and sexually transmitted disease: AIDS in Africa. *Journal of Health and Social Behaviour, 30:353-373.*

Igbinedion Eki (2000): Female Trafficking in Nigeria. This Day Newspaper. August.

Igbinedion versus Prostitutes This Day 2002.

Indian Council of Medical Research (1999) : AIDS Awareness among married women in India. *AIDS Care*

International Labour Organization (2000) HIV/aids: a threat to decent work, productivity and development. Documentation for discussion at the special high level meeting on HIV/aids and the world of work, Geneva 8 June.

Jeremiah, M.T (1997): " The role of the environment in the sexual activity of school students in Tororo and Pallisa districts of Uganda". *Health Transition Review Suppl Vol 7 pg 67-81*

Jinadu A and Odesanmi O (1993) : " Adolescent Sexual behaviour and condom use in Ile-Ife, Nigeria. *Clinical Nursing Res. Vol 2 (1) pg 114-15*

Kalibala, S and Kaleeba N (1989) : AIDS and community based care in Uganda: the AIDS support organisation, TASO. *AIDS Care*.1, 2: 173-175.

Kamenga, C. Ryder, R.W, Jingu, M Mbuyi, N Behets, F Brown C, & Heyward, W.L (1991) Evidence of marked sexual behaviour change associated with low HIV-1 seroconversion in 149 married couples with discoundants HIV-1 serostatus: experience at an HIV counseling centre in Zaire *AIDS, 5 61-67*

Kaunda A (1995) : Pressure to ban sexual cleansing in Zambia *AIDSAnalysis Africa. 5 2:4*

Kigadya, R.M Klokka, A et al (1993) Sentinel Surveillance for HIV 1-among pregnant

Kilmarx P et al (2000) Explosive spread and effective control of human immunodeficiency virus in northernmost Thailand: the epidemic in Chiang Rai Province. *AIDS 14 (17) 2731-2740*

Kisekka, M.N. (1992): Socio-cultural beliefs and practices related to condom acceptability among Hausa in Nigeria and Bagana in Uganda Unpublished.

Langford, I.H and Raithatha, N (2000) : Perceptions of HIV and

AIDS Amongst High School Students in Norwich, England. *University of East Anglia*

Lagarde E, Carael M, Glynn JR, Kanhonou L, Abega SC, Kahindo M, Musonda R, Auvert B, Buve A; Study Group on the Heterogeneity of HIV Epidemics in African Cities.

Lwihula G, Dahlgren, L., Killewo J and Sandstrom A (1999) : The AIDS epidemic in Kagara region, Tanzania: the epidemic of local people. *AIDS Care 5, 3: 347-357*

Loewenson R, Whiteside A. (2001) HIV/AIDS. Implications for poverty reduction. UNDP.

Levine, C (1995) Orphans of the HIV epidemic unmet needs in six US cities. *AIDS Care 7 (Supplement 1) : S57-S61*.

Malamba S.S, Wagner H.V, Mared G (1994) Risk Community as case – control; *AIDS 8, 1 253-257*

Malungo J.R.S (1999) Health seeking behaviour among STD patients and institutional responses to HIV/AIDS care in Zambia in Caldwell JC, Caldwell P., Orubuloye I.O, Ntozi PM, Awusabo-Asare, John Anafi, et al in towards the continent of the AIDS Epidemic.
Health Transition Review 129-142.

Mason K.O. (1994) HIV Transmission and the balance of power between women and men: a global view: In AIDS and Impact and Prevention in the Developing World: Demographic and Social Science perspectives, ed: S

Cleland and P. Way. Supplement to *Health Transmission Review 4* pg 217-240 *Caberra.*

Maswanya ES et al (1999), Knowledge, risk, perception of AIDS and reported sexual behaviour among students in secondary schools and colleges in Tanzania. *Health Education Research, 1999, 14 (2): 183-198.*

Matlin S and Spence N (2000): The Gender Aspect of the HIV/AIDS pandemic . Expert Group meeting on " The HIV/AIDS pandemic and its Gender Implications" 13-17 Nov.

Mbizwo MT and Massett MT, (1990) Reproductive health and AIDS prevention in sub-Saharan Africa: The case for increased male participation *Health Policy and Planning 11(1) 84-92*

McGrath JW, Rwabukwali CB, Schumann DA, Pearson-Marks J, Nakayiwa S, Namande B, et al (1993). Anthropology and AIDS. The cultural context of sexual risk behaviour among urban Baganda women in Kampala, Uganda. *Social Science and Medicine 36(4):429-39.*

Morgan, L.A (1989) Economic wellbeing following marital termination: a comparison of widowed and divorced women. *Journal of Family Issues 10, 86-101*

Morris L, Bailey P, Nunez L. (1987.) Young adult reproductive health survey in two delegations of a Mexico City. English Language report. Mexico city, centro de Orientation para Adultuos Jovenes

Nabaitu, J (1995) Marital Status instability in a rural population in South-

West Uganda: implication for the spread of HIV-1 infection. HIV/AIDS Surveillance Report, Ministry of Health Entebbe.

National AIDS Commission, Republic of Indonesia (2001) HIV/AIDS and other STIs in Indonesia. Challenges and opportunities for action. Jakarta: Republic of Indonesia.

National HIV/AIDS Reproductive Health Survey, Nigeria 2003

Niang C.I and Van-ufford P.Q (1996) The social –economic impact of HIV/AIDS on children in a low prevalence context: The case of Senegal. *AIDS, Public Policy and Child well-being*.

Nigeria, Federal Ministry of Health (2003) National Policy on HIV/AIDS Abuja.

National Committee on AIDS (2003) HIV/Syphilis sentinel sero-prevalence survey in Nigeria : Technical Report

Ntozi James. P.M (1997): AIDS morbidity and the role of the family in patient care in Uganda.. Vulnerability to HIV infection and Effects of AIDS in Africa and Asia *Health Transition Review* Supplementary to vol 7 .

Ntozi et al (1999). The effect of the AIDS epidemic on widowhood in Northern Uganda. In Orubuloye J.C. Caldwell, J.M Ntozi The continuing HIV/AIDS epidemic in Africa. Responses and copping strategies *Health Transition Review pp211-24*

Ntozi JPM and F.E.Ahimbisibwe (1999). Some factors in the decline of AIDS in Uganda . In Orubuloye J.C. Caldwell, J.M Ntozi The continuing HIV/AIDS epidemic in Africa. Responses and copping strategies. *Health Transition Review pp 93-107.*

Odujinrin, O.M.T (1991) " Sexual activity contraceptive practice and

Abortion among Adolescents in Lagos, Nigeria" *International Journal Gynaecology and Obstetrics Vol. 3.Pg 365*

Okeibunor, JC (1999) Threats of AIDS and Condom Use in a

Nigerian Urban Community: Implications for Fertility Regulation Sin Nigeria *UAPS vol 36*

Okeyo T.M and A.K. Allen (1994): Influence of widow inheritance in the

epidemiology of AIDS in Africa. African *Journal of Medicine Practices1, 1: 20-25.*

Okonofua, F.E. (1992) " Factors Associated with Adolescent Pregnancy in

Rural Nigeria "*Gynaecology and Obstetrics Obafemi Awolowo University. pg 8-9*

Onifade, I (1999): Unmet reproductive health needs of adolescents:

Implications for HIV/AIDS prevention in Africa.. In The continuing HIV/AIDS Epidemic in Africa : Responses and Coping Strategies. *Health Transition Review* (eds) Orubuloye, I.O Caldwell. J.C and James P.M, 66-72

Omideyi, A.K. (1986) " The status of women and fertility among Yoruba, a

proposal of study" Manuscript.

_____ (1990) " Women's position, conjugal relationships and

fertility among the Yoruba" *Journal of African Population Studies No4, pp. 22-35*

Oppenheim, M.K. (1994) HIV transmission and the balance of power between women and men : a global view in *Health Transition Review supplement to vol 4 pp217-240*

Orubuloye I.O, Caldwell, P and Caldwell, J (1993). The role of high risk occupation in the spread of AIDS: truck drivers and itinerant market women in Nigeria. *International Family perspectives 19,2:43-48, 71.*

Orubuloye I.O, Pat Caldwell, and John Caldwell (1994): African women's control over sexuality in an era of AIDS: a study of the Yoruba of Nigeria. In Orubuloye I.O, Caldwell, P and Caldwell, J (eds) Sexual Networking and AIDS in sub-Saharan Africa:

Health Transition Review vol 4 68-88.

Orubuloye I.O. and F. Oguntimehin (1999). Intervention for the control of STDs including HIV among commercial sex workers and students in Nigeria. In Orubuloye, I.O J.C. Caldwell, J.M Ntozi The continuing HIV/AIDS epidemic in Africa. Responses and copping strategies. *Health Transition Review pp 121-130.*

Orubuloye, I.O, Caldwell J, Caldwell P (2000): Perceived male sexual needs and male sexual behaviour in Southwest Nigeria. Orubuloye, I.O, Caldwell J, Caldwell P eds: Towards the Containment of the AIDS Epidemic: social and Behavioural Research)
Health Transition Review 1-20.

Osho A and B.A. Olayinka (1999): Sexual practices conducive to HIV transmission in southwest Nigeria. In Orubuloye, I.O, J.C. Caldwell, J.M Ntozi The continuing HIV/AIDS epidemic in Africa. Responses and copping strategies. *Health Transition Review pp 85-92.*

Otti PN and Rasekoai, M (1998): Factors influencing the spread of HIV/AIDS

in Lesotho Panos Institute(1989.) AIDS and Children: a family disease. London.

Owuananam D.O (1995): Sexual networking among youth in Southwestern

Nigeria in Orubuoye I.O. Caldwell JC. Caldwell Pat, Shin Jain: The third world AIDS Epidemic. *Health Transition Review suppl to vol 5 57-66*

Papanek, Hanna (1990). To each less than she needs, from each more than

she can do in Persistent Inequalities, (editor, I Tinker). Oxford University Press, New York. P 181.

Packard RM, Epstein P. (1991) Epidemiologists, social scientists and the structure

of medical research on AIDS in Africa. *Social Science and. Medicine 1991; 33(7): 771-94.*

Petty, R. E. and Cacioppo, J. T. (1981) Attitudes and Persuasion: Classic and

Contemporary Approaches, Dubuque, Iowa: Wm Brown Publishers

Pison, G, B le Guenno, E lagrde C, Enel and C seck (1993). Seasonal migration: a

risk factors for HIV in rural Senegal. *Journal of Acquired Immune Syndrome vol. 3.*

Piwoz E and Preble, E (2000) HIV/AIDS and Nutrition: a review of literature and

recommendations for nutritional care and support in sub-Saharan Africa. Nov USAID Washington DC Support for Research in Africa.

Preston-Whyte EM.(1995b) Halfway there. Anthropology and intervention-

Oriented AIDS research in KwaZulu/Natal, South Africa. In: Brummelhuis H, Herdt G, and editors. Culture and sexual risk. Anthropological perspectives on AIDS. Amsterdam: Gordon and Breach Publishers; 1995.

Reid E and Bailey (1992) Young women: silence susceptibility and the HIV epidemic, UNDP HIV AND Development Programme, issues Paper NO 12 UNDP NEW YORK.

Resources Centre for Adolescent Pregnancy Prevention (2004): Theories and Approach News letter.

Reuter Health (1999) Economic empowerment of women key to halting AIDS epidemic in Africa. *Medical News 14 October*.

----------(1999b) HIV/AIDS devastating economies in sub-Saharan Africa. *Medical news 13 October.*

Rosenvard, C and Campbell, T. (1996): A review of sexual behaviour change studies from sub-Saharan Africa: what lessons can we learn for the future? Lusaka, Zambia, International Conference on AIDS. Jul 7-12, 11

Rowley, Jane T, Anderson and Ng T. Wang (1990) " Reducing the spread of HIV infection in sub-Saharan Africa: some demographic and economic consequences" *AIDS 4, 47-56*

Roy Anderson (1989) : The transmission dynamics of sexually transmitted diseases. The behavioural component in sexual behaviour and networking : Anthropological and Socio-cultural studies on transmission of HIV. *Health Transition Review.*

:Rugamela G (1999) HIV/AIDS and the commercial agriculture sector of Kenya: impact, vulnerability, susceptibility and copping strategies. Institute of Social Studies, The Hague.

Salaka F. (1996).. AIDS/STD Health Promotion Exchange *Country watch: Zambia.* 1: 10-11

Safo, M 1993. AIDS is real. The Miror (Ghana) 2 October 8 .

Schoeff, B.G (1988) : "Women, AIDS and Economic Crisis in Central Africa" *Canadian Journal of African Studies 22:625-644.*

Schoeff BG.(1991) Ethical, methodological and political issues of AIDS research in central Africa. *Social Science and Medicine 33(7):749-63.*

Seeley, J . Rajura E, Bachengana C, Okongo, M Wagner , U and Mulder D `(1993) The extended family and support for people with AIDS in a rural population in South west Uganda: a safety net with roles *AIDS Care 5,1 :117-122.*

Selwyn, P.A. E.E Schoenbaum, K Daveim et al (1989) : Prospective study of Human Deficiency Virus and pregnant outcome in intravenous drug users. *Journal of America Medical Association 261: 1289-1294*

Serwadda, D, R.H Gray, Wanerrel et al : (1999) HIV, STDs and Fertility: a population based study in Rakai District, Uganda

Setel, P (1997): " A plague of paradoxes: AIDS, Culture and demography in Northern Tanzania." Unpublished manuscripts.

Sewankanbo, N.M, R. Gray, D Serwadda, L R.T Shalling, S.D (1987): Demographic Impact of HIV Infection in rural Rakai District, Uganda, results of a population based cohort study : *AIDS 8: 1707-1713*

Silva K, Tudor S.L, Schensul JJ et al (1997): Youth Sexual risk in Sri-Lanka. JCWR Research Reports Series No 3 (Women and AIDS Research Program) Washington D.C

Shorter E (1992): What can historical examples of sexual transmitted disease teach us about AIDS? In sexual behaviour and networking : Anthropological and Socio-cultural studies in the Transmission of HIV . *Health Transition Review ed Tim Dyson Lieje.*

Spence Nancy and Matlin Stephen (2000) "The Gender Aspects of HIV/AIDS Pandemic " Expert Group meeting Commonwealth Secretariat London

Sowell R (1997) Resources stigma and patter of disclosure in rural women with HIV infection "*Public Health Nursing 14 (5) 302-312*

Stoddard T. (1994): Don't call it AIDS: HIV disease is more appropriate. The new York Times Aug 17

Tavern B. (1996). Communication strategy and stigmatisation of women: levirate and AIDS in Burkina Faso. *Science et Sante' 142:87-106.*

Tiou S, Norr K, McElmurry B. (1995). AIDS prevention for women: a community-based approach in Botswana. Geneva, Switzerland, 8-11 February

Turner R.J (1981) : Social support as a contingency in psychological well-being. *Journal of Health and social Behaviour 22 : 357-369.*

TWA-Twa, J Nakanaabi I,and Sekimpe D (1997). " Underlying Factors in Female Sexual Partner Instability in Kampala.

Uche C, Isuigo-Abanihe (1994) : Extramarital relations and perception of HIV/AIDS in Nigeria Health Transitional Review 4, 1994 111-125.

UNICEF (2001) Situation Assessment and Analysis of Children's and Women's Rights in Nigeria: A Wake-up Call.

UNAIDS (2000) Female sex worker HIV prevention projects: Lessons leant from Papua New Guinea, India and Bangladesh. Geneva UNAIDS

_____ (2000) : Global AIDS Report

_____ (2001) : G Global AIDS Report

_____(2002a) : Gender and HIV/AIDS

----------(2002b): UNAIDS Tracks Global Impact of HIV/AIDS Fact Sheet

_____(2003) Global AIDS Report

_____(2004) : Global AIDS Report

_____ (2000). Innovative Approaches to HIV Prevention. Selected case studies. UNAIDS/00.35E, October.

_____. 1999 World AIDS Campaign: Facts and Figures. February .

United Nations Children's Fund (UNICEF). *Young People and HIV/AIDS: Opportunity in Crisis*. New York, NY: UNICEF, 2002.

UNICEF (2000) : The State of the World's Children . UNICEF, New York

UNFPA (2001) Saving Women's Lives Fact Sheet.

UNDP (1999) " Gender and the HIV epidemic, Dying of sadness gender sexual violence and the HIV epidemic".

Yamba, C.B (2001) : Cosmologies in Turnmoil: Wicthfinding and AIDS in Zambia. Indiana University Press

Von Reyne C.F. (1990): Epidemiology of HIV infection in Africa. *AIDS vol. 2*

Warner, D Lee and Robert A. Hatcher. (1998) " Male Condoms" In Roberts A. Hatcher et al, eds. Contraceptive technology, 17th edition, New York Ardent Media.
Society April –May 3,8.

Wasserheit J.N (1992) *Epidemiologic synergy*: Interrelationships between HIV and other STDs Sexually transmitted Diseases 19:61-77

Webb, D (1997) HIV and AIDS in Africa. Pluto Press, London.

Weinhardt, L. S, Carey M.P, Johnson, B.T and Bickham, N.L (1999) Effects of HIV Counseling and testing on sexual risk behaviour: a meta-analytic review of published research, 1985-1997. American *Journal of Public Health, 89 (9) 1397-1405*

Weiss E and Udo A (1979) " The Calabar Rural Family Planning Project:1975-1979: What we have learned about Family Planning" Ppaer presented at the National Workshop on Population and Economic Development in Nigeria in the 1980s. The University of Lagos, 12-14 Sept

World Bank (2000) Intensifying Action Against HIV/AIDS in Africa.

World Health Organisation/ROYAL INTITUTE/SAFAIDS (1995a) Facing the challenges of AIDS, STDs: A gender-based response, SSN, the Netherlands

World Health Organisation (1995b) : AIDS Statistics: *AIDS Care 7,2:245-248*

WHO 2002:Women's health In South-East Asia Report. Geneva

World Health Organization. The context of young people's sexual relations. *Programme on Reproductive Health Res* 2000;53:2-3

Zellner Sara L 2003: Condom Use and Accuracy of AIDS Knowledge In Cote d'Ivoire: International Family Planning Perspectives Vol 29, No 1 March

Appendix 1

DEPARTMENT OF DEMOGRAPHY & SOCIAL STATISTICS

FACULTY OF SOCIAL SCIENCES

OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE

QUESTIONNAIRE IDENTIFICATION | | | | |

SOCIO-ECONOMIC CONSEQUENCES OF LIVING WITH HIV/AIDS

BASSELINE SURVEY

LGA……... | | |

NAME OF COMMUNITY\NEIGHBOURHOOD…… | | |

CLUSTER NAME…… | | | | |

INTRODUCTION

My name is …… we are conducting a survey on Socio-economic consequences of living with HIV/AIDS in Lagos state. We would appreciate your participation in this survey. The survey usually takes between 20 to 30 minutes to complete. Whatever information you provided will be kept strictly confidential and will not be shown to other person. Participation in this survey is voluntary and you can choose not to answer any individual question or the entire questions. However, we hope that you will participate fully in this survey since your views are important. May I begin with the interview now?

Signature of Interviewer …….. Date…….

RESPONDENT AGREE TO BE INTERVIEWED……..1 ⟶ Continue

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED…..2 ⟶End.

INTERVIEW LOG

VISIT	1	2	3
DATE			
INTERVIEWER			
COMMENT			

Checked by Supervisor: Signature…… Date……...

SECTION A SOCIO-ECONOMIC CHARACTERISTICS

Sex 1. Male 2. Female

In what month and year were you born

Month… | ☐

Year | ☐

(Record 88 for don't know and 99 for no response)

2. How old were you at your last birthday?

Age……..

(COMPARE AND CORRECT Q102 IF NECESSARY)

3. What is your marital status?

Single 2. Married. . 3 Divorced 4 Widow\Widower 5.Other

Don’t know 99. No Response

4 Does your spouse have other wives?

(for women only)

Yes No → skip to Q107

88. Don’t know. No Response.

5.. Do all wives live in the same

compound\house? (for women only)

Yes 2 No. 88. Don’t know 99. No Response.

6. What is your ethnic group?

Yoruba 2. Igbo 3.Hausa. 4 Fulani 5 Other

Don’t know No Response

7. What is your religion?

Christianity 2. Islam 3.Traditional religion

Others (specify) 5 Don’t know 99 No Response

8. What is your highest of level of education……

9. What is your income per month…….

10. Age at First Intercourse

SECTION B : HOUSING INVENTORY

11. Total number of rooms in the main house

occupied or used by household?…….

12. What material is the roof of the house made of? 1. Zinc 2. Asbestos 3 Aluminum 4. Others.

13. What material is the floor of the house made? of? 1 Cement 2. Mud 3 Tiles 4 Wood 5 Others.

14a. What material is the wall of the house made of? Brick 2. Plank 3.Others

14b.Do you own this house or it is rented?
Own 2. Rent 3. Non payment 4. Others
88. Don't know 99 No response

15. What is the source of lighting?
i. Electricity ii. Candle iii. Kerosene Lantern
Gas Lamp Don't know No response

16. Where do you get drinking water?
Stream Borehole Tap inside the house Public tap
Well Rain water Bought from vendor 88. Don't know
99. No response.

SECTION B: SEXUAL BEHAVIOUR AND NETWORKING

17. Have you had sexual intercourse with anyone (else) in the last 12 months (other than a spouse)? 1. yes 2 No 3 Don't know
(Please include the following that you might have sex with)
Mistress 1. Yes 2 No
Girlfriends 1. Yes 2 No

Casual partner 1. Yes 2 No

Prostitute 1. Yes 2 No

18. With how many different people have you had sexual intercourse within the last 12 months (apart from spouse (s))? Number….

19. Where did you have sex the first time with him/her

1. Same city 2. Other urban area 3. Rural area

20. (If outside this city) Why were you there? Was it for (Read out)

1. Professional reasons 2. Family reasons 3. Economic reasons 4 Others Specify

21. (If outside this city) How long did you stay in that place? Days……

22. How long did you know him /her before having sexual relation? Months.. Days…

23. Are these sexual relations currently going on or has the sexual relationship ended?

1. Relationship going on 2. Relationship ended 3. Don't Know

24. In your last intercourse with him\her, did you use a condom

1. Yes 2. No 3. Don't know.

25. Usually did you use a condom with him/her? (Read out)

1. Always 2. Most of the time 3. Rarely 4. Never

How much did you normally buy a pack of condom…….

Is condom available in the chemist/Pharmacy shops

1 Yes 2. No

26. Did you give /receive money in exchange for sex with him/her?

1. Yes Always 2. Yes often 3. Never

27. Do you aware that over the last year, apart from you, he /she has sex with (Read out)

a. Steady partner 1. Yes 2. No

b. Casual partner 1. Yes 2. No

c. Others with exchange of money 1. Yes 2. No

28 Did you take or your partner took alcohol before having sex

SECTION C: SEXUALLY TRANSMITTED DISEASES

29. Have you heard of sexually transmitted diseases?

I Yes 2. No

30. Which of the STDs have you heard of?

a. Gonorrhea 1. Yes 2. No

b. Syphilis

c. HIV/AIDS

d. Herpes

e. Candiasis

f. Others

31 From which source?……..

32. Have you contracted STDs before? 1. Yes 2. No

33. How did you know that you had venereal disease……..

34. From whom did you get it

1. Spouse 2. Extramarital partners 3. Prostitutes 4. Others

35. Did you seek treatment? 1.Yes 2. No

36 Where did you seek treatment?

Government hospital\Clinic……

Private hospital\Clinic……

Health worker……..

Medicine store\chemist

Traditional Birth Attendant. 88. Don't know

37. In the recent past, how much does it cost you to treat the venereal diseases?

Facilities	Cost (N)
Government hospital\Clinic……	
Private hospital\Clinic……	
Maternity home……..	
Medicine store\chemist	
5. Traditional Birth Attendant.	
88. Don't know	

(Note: Pls indicate cost using the code below)

0-N1000……1

N1001- N2, 000…….2

N2001 + ……3

Don't know……4

38. Did you tell (any of) your spouse(s) or partner(s) about this?

1. Yes 2. No

39. While you had the symptoms , did you do anything to prevent passing the infection to (any of) your spouse (s) or partner?

1. Yes 2. No

39. If yes , what did you do? 1. Abstain from sex 2. Use a Condom 3. Others

40. Are you circumcised? 1. Yes 2. No

Question 41- is for Women only

41. Do you usually use something to tighten or dry your vagina before sexual intercourse? 1. Yes 2. No

42. If yes, What do you use?…….

43. Have you heard of Vagina Microbicides? 1. Yes 2. No

44. Would you like to use it 1. Yes 2. No

SECTION D: PERCEPTION AND ATTITUDES TOWARD PEOPLE LIVING WITH HIV/AIDS

45. Have you ever heard of HIV/AIDS 1. Yes 2. No

46. Source (s) of information……

47 What is your HIV status 1. Positive 2. Negative 3. Don't know

48. If your answer to 45 is Don't Know would you be willing to do HIV screening? 1. Yes 2. No

49. If your answer is no why do you think you might not be willing to do HIV screening 1. Religion 2. Afraid of possible test result 3 No reason 4. Don't Know.

50. If you are tested positive what will you do?……

51 If your partner is tested positive what will you do?…….

52 If you are tested positive will you disclose your HIV status to

Family	1. Yes No 2
Wife	1. Yes No 2
Children	1. Yes No 2
Friends	1. Yes No 2
Religious member	1. Yes No 2

53 Since you have heard of HIV/AIDS have you changed your sexual behaviour?1. Yes 2. No

54. If yes, what did you do? 1.. Abstain from sex 2. Use condom 3. Stay with one partner

55. If no to question 48, why?

56. In the past 2 years , have you seen an increase in the number of people living with HIV/AIDS? 1. Yes 2. No

57. Do you have friends or relatives living with HIV/AIDS? 1. Yes No 2.

58. If yes to question 56 what was your reaction

59. Do you have friends or relative that have died of HIV/AIDS? 1. Yes 2. No

60. If yes, to question 58, what is your reaction when you heard of it……

61. Can you do the following with PLWHA

Eat together	1. Yes No 2
Sleep together	1. Yes No 2
Shake hands	1. Yes No 2
Hug each other	1. Yes No 2
Share the same toilet	1. Yes No 2
Play together	1. Yes No 2

62. If no to any of the questions in 61 above why?

63. If yes to question 57 ,did you support the wife\husband and children of the deceased? 1. Yes No 2

64. What did you do?…….

65. Are the children and wife/husband taken care of by the family? 1. Yes No 2

66. If no why?

67. What are the needs of their children?

Financial support
Educational support
Life skill training
Medical support
Socio-emotional support
Others

68. Have the children been told of the cause of their parent(s) death 1. Yes No 2

69. If no why?……

70. Do you feel the need that youth should know about HIV/AIDS and related issues? 1. Yes 2. No

71 Do you discuss about HIV/AIDS and related issues in your family? 1. Yes 2. No

72. What do you think government can do to reduce the scourge of HIV/AIDS.

73 What are the needs of PLWA

i

ii

iii

74. What Support should government give them?

75 Do you think PLWA should have children? 1. Yes 2. N0

76. If no why?……..

77. Do you think PLWA should hold public office? 1. Yes 2. No

78. If no why?

Thanks

Appendix 2

DEPARTMENT OF DEMOGRAPHY & SOCIAL STATISTICS

OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE.

IN-DEPTH INTERVIEW QUESTIONNAIRE FOR PEOPLE LIVING WITH HIV/AIDS IN LAGOS STATE.

SECTION A SOCIO-ECONOMIC CHARACTERISTICS

1. SEX----------

2. How old are you at your last birthday?…….

3. What is your occupation?……

4. What is your marital status?……

5. What is your ethnic group?…….

6. What is your religion?…….

7. Kindly estimate your income……

8. What is your highest level of education

9. Did you do any of the following(s)

Drink alcoholic

Smoke

Visit film houses

Visit club houses

SECTION B HIV/AIDS HISTORY

10. How did you get to know about your HIV/AIDS status?

11. What type of virus do you had?

12. How did you feel when you are told that you are infected

13. Have you told anybody of your situation

14. If yes, who and when (probe: if family, wife, friends, pastor, religious member)

15. If not why?

16. If, yes to question 10 what was the reaction of your family members

17. when they learnt about your status.

18. Do people in your neighborhood know your HIV status?

19. If yes, how did they know?

20. Did you discuss your status with your children?

SECTION C: SEXUAL BEHAVIOUR

21. Before diagnosed for HIV/AIDS have you ever contracted any vulneral diseases?

22. If yes, which of the STDs……

23. Did you seek treatment?

24. If yes, where……

25 If no, why

26. After you had been diagnosed, did you continue to have sexual intercourse? With whom? (probe)

27. Are you still maintain multiple sexual partners

28. If yes, while you had the symptom, did you do anything to prevent passing the virus to any of your spouse(s) or partner(s)

29. What did you do?

30. What is your attitude towards condom use

31. Do you have access to condom

32. Are you circumcised?

33. Since you have tested positive, is there any changes in

nutritional status.

34. If yes how? (probe)

SECTION D: SOCIAL AND ECONOMIC CONSEQUENCES

35. Since you have been diagnosed for HIV/AIDS, what type of treatment, if any, are you on?

36. Where did you receive the treatment?

37. How much did you normally spend on retroactive drugs per week?

38. Has your status affects the needs of your family?

39. If yes, how?

40. What are the needs of your family (probe)

Care needs

Support need (shelter, food, clothing, education, etc)

Children schooling (who pays school fees, provide uniforms and books)

41. Is there any dropouts and reasons for drop out from school among your children

42. Is there any discrimination against you in your working place?

43. Is there any discrimination against you among your friends?

44. Is there any discrimination against you among your religious group?

45. Is there any discrimination against you among your family members?

46. Is there any discrimination against you in the health facilities?

47. What is the attitude of the community or neighborhood towards PLWHA?

SECTION E: CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS.

48. If you have informed your family members, what contributions are they making towards the care and support of your family

49. Is there any place where you can received treatment (free or subsidized)

50. If yes, where?

51. Do you know of any place where you or your children can get support? Where?

52. What do you think about joining groups of PLWHA where those infected meet and encourage themselves.

SECTION F :INFORMATION ON PLWA

54. How do you get information in regards to health and AIDS (probe for

preferred media)

55. What type of radio programme (s) do you like to listen to?

56. Do you read magazine \Newspaper?

57. Any other suggestion

Thanks.

Appendix 3

DEPARTMENT OF DEMOGRAPHY & SOCIAL STATISTICS

OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE.

IN-DEPTH INTERVIEW QUESTIONNAIRE FOR PEOPLE AFFECTED HIV/AIDS IN LAGOS STATE.

Section A: Socio-Economic Characteristics of the Respondent

1. SEX----------

2. How old are you at your last birthday?…….

3. What is your occupation?……

4. What is your marital status?…….

5. What is your ethnic group?…….

6. What is your religion?…….

7. Kindly estimate your income……

8. What is your highest level of education

Section B: General Knowledge

9. What do you know about HIV? Also what do you know about AIDS?

10. What are the common beliefs about HIV/AIDS in your community?

11. How is HIV contracted, that is how is it passed on from person to another.

12. How can a person avoiding contacting HIV?

Section C: Diagnosis

13. How did you know that your relative is HIV positive? Who made the disclosure to you.

14. Were you counseled before you were told that your relation is HIV positive?.

Section D: Treatment

15. What is your role in the treatment for the illnesses affecting your PLWA?

16. What has been the attitude of doctors, nurses and other health workers towards your relation since he /she tested positive?

17. What has been the attitude of doctors, nurses and other health workers towards your relation since he/she tested positive.

18 .Have you ever taken him /her for alternative

(traditional)medicine/treatment?

19. Have you ever taken him/her to a religious institution for treatment?
20. At the time of diagnosis, what was done in terms of referral?
21. What degree of follow –up has been done by health facilities (if any)

Section E: Socio-Economic Consequences

22. Please describe the feeding habits of PLWA?
23. Who else in your family is aware that your relation has HIV/AIDS?
24. If has not shared status why?
25. Can you describe your reactions when your PLWA declared his /her status and the relationship that has been existing between you and this person
26. Has the demand of PLWA affected relationship between him /her and members of the family?
27. Is the employer of your PLWA aware of his/her status.
28. If yes what was his/her reaction to the news of his/her sero status. Was there any threat of job loss?
29. Since knowing about your PLWA's sero status, what are the special needs you have been experiencing.

30. Will you be prepared to be an advance for the prevention by speaking up in the public about the situation or standing by your relation if he/she wishes to declare his/her status publicly?

31. What suggestions do you have for government that will improve the welfare , care and support for PLWA.

CONSENT FORM FOR PLWHA

SOCIO-ECONOMIC CONSEQUENCES OF LIVING WITH HIV/AIDS

BASSELINE SURVEY

My name is …… we are conducting a survey on Socio-economic consequences of living with HIV/AIDS in Lagos state. We would appreciate your participation in this survey. The survey usually takes between 20 to 30 minutes to complete. Whatever information you provided will be kept strictly confidential and will not be shown to other person. Participation in this survey is voluntary and you can choose not to answer any individual question or the entire questions.

Do you agree to be interviewed? Yes --- No----

Signature Date